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Leadership Development to Support Quality Improvement

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Abstract

This study examines the possible benefits of combining a standards-based quality improvement and accreditation programme with a skills-based leadership development programme. A mixed methods approach was used to explore how a small selection of key stakeholders from the local health system and technical partners experienced two existing programmes, which for the first time were combined. Thematic analysis was used to identify categories in the data from semi-structured interviews, which were grouped into six themes. Secondary statistical data was reviewed to assess whether there was any direct improvement in the compliance with the accreditation standards. All respondents identified that there were benefits in combining the programmes. The hospital respondents continued to use the managing and leading practices and improvement methods although the leadership input was not maintained. There was a strong correlation between the leadership and quality improvement although time did not allow for this to be demonstrated in the standard compliance scores. The study provides useful insight into the role of leadership and followership in quality improvement, that may be of use to others when implementing health and other related development programmes in low and middle-income countries. Areas for future research are identified.

Key words: Quality improvement, Health management, Leadership, Mixed methods, Low Middle-Income Countries, African Health Research.

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In loving memory of my dear mother Jean and my best friend Jenny, who left too soon to see this finished.

Glossary

BOTUSA:	Botswana USA partnership - of the Government of Botswana and the Centers for Disease Control and Prevention (CDC)
COHSASA:	The Council for Health Service Accreditation of Southern Africa NPC
CoQIS:	COHSASA Quality Information System
ISQua:	International Society for Quality in Health Care
LDP:	Leadership Development Programme
MOH	Ministry of Health
MSH:	Management Sciences for Health
PEPFAR:	The United States President's Emergency Plan for AIDS Relief
QI:	Quality improvement
QIL:	Quality Improvement and Leadership Programme
SA-HCD:	Southern African Human Capacity Development Coalition
USAID:	United States Agency for International Development

Chapter 1: Introduction

This research project is to explore and evaluate the effectiveness of introducing a leadership development programme simultaneously with a quality improvement and accreditation programme. Both programmes have been implemented successfully in a number of healthcare facilities in different countries. The two programmes were introduced previously in the same facilities at different times, where there appeared to be no relationship made between the two.

Across Africa health systems have been under pressure for many years from the burden of diseases such as HIV / AIDS, Malaria, Tuberculosis as well as the impact of poverty related diseases such as malnutrition. Rising morbidity and mortality from chronic diseases co-exist with an even greater burden of infectious disease, which still accounts for at least 69% of deaths on the continent (Young et al, 2009). In addition, there is increasing evidence of adverse interactions between some chronic diseases and infectious diseases. (de-Graft Aikins et al 2010).

Furthermore, there are shortages of high calibre management staff, doctors, nurses and other professionals. A shortage of trained and qualified staff remains one of the major bottlenecks towards the availability of quality health care in Botswana (Integrated Health Service Plan, Botswana 2010 page 11).

The Millennium Development Goals set by the United Nations in 2000, included three specific health goals; goal 4: Reduce child mortality; goal 5: Improve maternal health; goal 6: Combat HIV/AIDS, malaria and other diseases. In response to these and other national and international goals, the World Health Organisation reviewed its own operations and how it could provide more effective support to member states. The approach was set out in the document *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. (WHO 2007). In her foreword to the document the Director-General, Dr Margaret Chan wrote,

"The best measure of a health system's performance is its impact on health outcomes. International consensus is growing: without urgent improvements in the performance of health systems, the world will fail to meet the health-related Goals". (WHO, 2007 p iii).

The framework describes health system strengthening using six building blocks. See Figure 1.

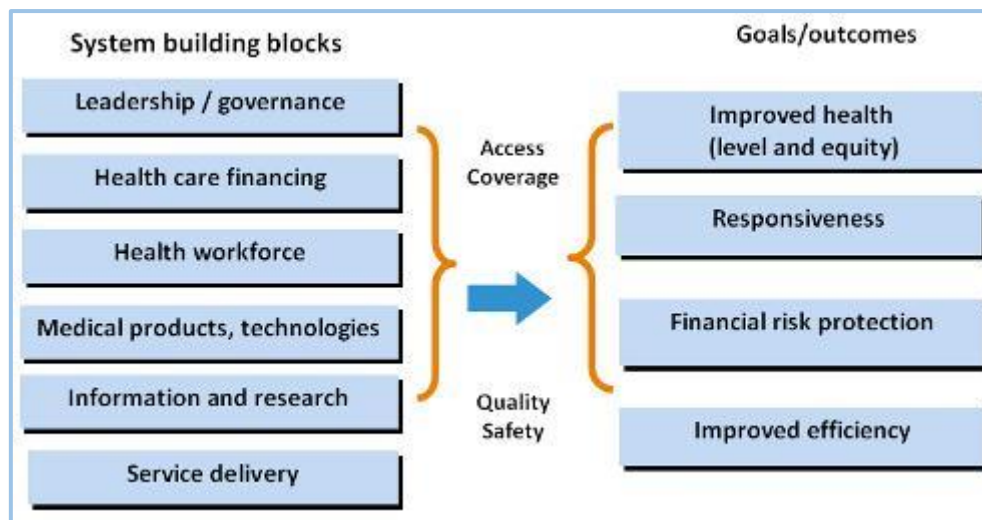


Figure 1: The WHO Health Systems Framework (World Health Organisation 2007) page 3 (Used with permission)

These initiatives have lead Ministries of Health in many countries and the aid agencies that support them, to focus on health system strengthening to improve service delivery and develop the capacity and capability of those employed in health systems with an emphasis on good, accountable management and leadership at all levels of health systems to ensure services are delivered effectively to patients.

The Council for Health Service Accreditation of Southern Africa NPC, (COHSASA) is an independent, non-profit, non-governmental organisation that was established in 1995, after the first free elections in South Africa brought democracy to the country. It was started by Dr Stuart Whittaker with thirteen founding members. COHSASA introduced voluntary quality improvement and accreditation programmes, designed to assist the health services in the country to address the inequalities in services created by the former apartheid regime. Since then COHSASA has expanded its footprint to twelve countries across the African continent.

COHSASA's quality improvement and accreditation programmes are standards based. The standards are for healthcare facilities and describe what needs to be in place in terms of structure, function and process across all areas of a healthcare facility in order for the staff to function optimally and for care to be delivered to patients effectively and efficiently. The standards have measurable elements (criteria), which are evaluated and scored to indicate the level of compliance with the standards. Examples of the standards are given at Appendix 1. The evaluation is carried out by experienced surveyors who examine documentation such as policies, procedures, maintenance records, personnel records, adverse incident reports and infection prevention and control monitoring reports for completeness. They observe staff across all departments to ensure policies are implemented and procedures carried out. They

interview staff and patients and triangulate the findings to ensure consistency of measurement across the healthcare facility. COHSASA as an organisation has been accredited four times by the International Society for Quality in Healthcare (ISQua) since 2002 (<http://www.isqua.org>). Various sets of its healthcare facility accreditation standards and its surveyor training programme have also been accredited. Currently COHSASA is the only African accreditation body that has been accredited internationally¹. ISQua's International Accreditation Programme (IAP) is the leading International Health Care external evaluation programme of its kind.

When I first joined the company, there was little management training included in the programmes offered. Previously there had been some programmes provided by consultants from the University of KwaZulu-Natal but these had been stopped because of funding issues. While I was still on the staff of the NHS Leadership Centre based in London in 2005, we were asked by COHSASA to provide two management development workshops, to support the quality improvement and accreditation programme the company was running for a provincial department of health. I was asked to lead these training programmes because of my experience of South Africa. I emigrated to South Africa with my family and did my high school education and nursing training in Cape Town where I worked in both the public and private healthcare sectors.

We carried out the two workshops for a group of eighty-four senior hospital managers and clinicians in one province in South Africa, and for many it was the first time they had been given any formal management training. A large number of managers and clinicians had been promoted into positions that were outside their areas of expertise and many into posts for which they were not equipped. During this training, it became clear that as well as management skills and expertise, the groups had not been given any form of leadership skills development.

When I left the UK National Health Service and joined COHSASA in December 2005, I developed a proposal to provide some management and leadership development specifically to support the COHSASA quality improvement and accreditation programme, which was accepted by the management and Board of COHSASA. The programme was piloted with one group of senior managers and clinicians who were in hospitals enrolled in the COHSASA quality improvement and accreditation programme. This worked well but it was decided by the senior management not to pursue the programme as feedback from some clients, mainly provincial departments of health indicated that they viewed it as an additional cost and the programme had no

¹ T. Fortune Letter ISQua 2016

academic recognition. The standards based quality improvement and accreditation programme was not an academically based programme. The training provided was skills based. Participants were awarded certificates of attendance only.

I was responsible for managing relationships between clients and the company. A key aspect of this work was to ensure that the programmes delivered, met the needs of the clients and genuinely assisted the healthcare facility staff to improve the quality of service to patients. Having identified leadership as a main factor in the success of the quality improvement and accreditation programme, but with the decision not to pursue the in-house programme it was important to investigate opportunities to address this.

Subsequently, COHSASA was invited to become part of the Southern African Human Capacity Development Project (SA-HCD), which was developed to strengthen health systems and their workforces to better deal with the HIV / AIDS pandemic. The SA-HCD was funded by the United States Agency for International Development (USAID) President's Emergency Fund for AIDS Relief (PEPFAR). A coalition of five NGOs was formed to introduce their various programmes in tandem in two countries. One of the other partners was the USA based NGO, Management Sciences for Health (MSH) (www.msh.org) which had a leadership programme. The Leadership Development Programme (LDP) was developed by MSH in 2005 and has been used widely around the world. The programme has been further developed subsequently with an on-line version. MSH personnel have extensive experience working in African countries and other resource poor settings. The LDP did not have any academic accreditation.

In Botswana where the research was located, the Ministry of Health was already exploring how to develop a programme of quality improvement and accreditation for its healthcare facilities against internationally accredited standards and had engaged COHSASA in negotiations.

Late in 2009, the coalition lead was asked to explore the opportunity of introducing the concept of the SA-HCD coalition in Botswana. During detailed discussions, it was agreed that only the COHSASA Quality Improvement and Accreditation programme and the MSH Leadership Development Programme (LDP) would be included for Botswana. The United States Agency for International Development (USAID) funding was arranged and monitored by the Botswana USA Partnership (BOTUSA), the partnership between the Botswana Government and the United States Center for Diseases Control and Prevention (CDC). The SA-HCD programme finished in 2010. At that point BOTUSA agreed to continue to fund the project with the two organisations working with the Ministry of Health.

With the experience of working in the first two countries, the project lead for COHSASA and the MSH project lead, had developed a good working relationship. They discussed with the coalition lead and respective management the opportunity to work more closely together.

The LDP process required facility staff to identify a problem to which the managing and leading practices could be applied in order to find solutions. Evaluation of the facility against the COHSASA standards identified all the deficiencies – that is where the various departments are not compliant with the standards. These deficiencies or problems are identified objectively and are not subject to the preferences of the staff. It was agreed to introduce both the LDP and the quality improvement and accreditation programme in a structured, systematic way using the data collected on compliance of the facilities with the COHSASA standards, available through the COHSASA web-based Quality information system (CoQIS). The system is used to support the monitoring and evaluation process of the quality improvement and accreditation programme. CoQIS was developed in 2006 and data that had previously been captured into an Access database was migrated to it. There is data in the system that dates back to the year 2000.

Detailed discussions were held between COHSASA, MSH and the Ministry of Health and it was agreed to integrate the activities and present one programme, the Quality Improvement and Leadership programme (QIL). COHSASA and MSH anticipated that by combining the programmes' delivery, rather than delivering separately, would result in a benefit in terms of learning and development for the candidates. A project plan was developed with a view to the combined inputs and activities enabling the facilities to achieve accreditation within two years.

A lot of work went into designing the training interventions. The COHSASA programme required the facility staff to understand and be able to interpret the standards and thus be able to carry out self-evaluation of their own area against the standards. The first training provided by COHSASA for the facility staff was a three-day workshop on how to understand and interpret the standards. They were given information on the development and structure of the standards and shown that the standards are scored by aggregating the scores of the criteria, which are the measurable elements of the standards. The criteria are weighted according to their importance in relation to safety and legality: the more serious the severity, the higher the weighting. Participants were given case studies to assess against the standards, which were discussed with the group. They then carried out 'mock surveys' in various departments of the hospital, during which they evaluated the physical facilities, systems and processes against the

criteria. These were discussed and reviewed to ensure they were able to assess the compliance and rate each criterion as non-compliant, partially compliant, compliant or not applicable. Each criterion includes a guideline on what supporting information and evidence is required to ensure full compliance. Staff were taught how to develop quality improvement plans to move standards towards compliance. Facilitation and practical support was provided to facility staff on-site to ensure they were able to evaluate the situation accurately and to implement improvements to achieve compliance with the standards. The practical support could include how to develop policy and procedure documents; how to identify indicators to measure for improvement or how to carry out clinical audits. More training can be provided relating to specific deficiencies or needs as the programme progresses.

The training provided by MSH for the LDP had two main themes; leading and managing practices and improvement methods and techniques. The leading and managing practices covered the leadership skills of scanning, focussing, aligning / mobilising and inspiring; the management practices of planning, organising, implementing and monitoring and evaluating. The training used the MSH 'Challenge Model' which required the participants to identify a problem, turn it into a challenge and then use the leading and managing practices and various improvement techniques, such as the Fishbone method or the five-whys, to deal with the challenge.

In the combined programme, the participants were introduced to the overall concept of the programme and underwent the standards interpretation training. Thereafter the baseline survey was carried out which provided objective information for the Challenge Model. The leading and managing practices training was then implemented, constantly referring to the standards compliance data to provide the context. The various improvement methods were applied to each selected problem or challenge, that is the non-compliant criteria. A selected group of staff were also trained to capture the standard compliance data into CoQIS. Unit managers and quality coordinators were trained to use the data in CoQIS to manage their quality improvement activities and to update the progress report with comments on their achievement, including setting due dates for activities and the names of the responsible people. Visits to the facilities were carried out every eight weeks to validate the self-evaluation data and provide onsite coaching and facilitation. The data was then available to support and refine further training.

A challenge was that both programmes had been implemented successfully over a number of years and trying to combine them required there to be a sharing of expertise, adaptation of language as well as some adaptation of the delivery methods and

organisation culture. There were staff in the Ministry of Health who had been involved with the respective programmes and felt a sense of ownership of that programme and to some extent felt any change could be a compromise of the work they had been doing. Furthermore, both companies, COHSASA and MSH had strong profiles and identities with their respective programmes in the region.

This study used an ethnographic approach in order to explore how a small selection of participants experienced two existing programmes, which for the first time have been combined. This research has explored the experience of a small representative sample of participants in order to understand their perception on undertaking the combined programmes. Secondary statistical evaluation data which was collected by the organisations provided a before and after baseline to indicate any improvement in learning outcomes assessment. However, this study was more concerned with understanding the qualitative experience of the participants. There was also opportunity to consider possible areas for change and improvement for MSH or COHSASA in any future development of the collaboration.

The following chapters describe the research and the processes used.

Chapter two covers the terms of reference of the project, including a review of the available literature. This clearly sets out the research questions and the boundaries within which I was operating.

The research approach and data collection methodology is described and discussed in chapter three. In this chapter I will explain the reasons for choosing the mixed methods approach to the project.

Chapter four describes and analyses the project activity undertaken, including the development of questions for and the application of the semi structured interviews. In addition, secondary data relating to the compliance with the COHSASA standards is discussed.

Chapter five sets out the findings of the research and of the major results.

In chapter six the findings and results are analysed and discussed in the context of the local setting and previous work undertaken in this field. It also explores the benefits and limitations of the study methods utilised.

Chapter seven sets out the conclusions and recommendations specifically for COHSASA and MSH as the developers of the Quality Improvement and Leadership Programme and includes recommendations for clients implementing the programme. This chapter also goes on to consider the wider implications for practice and

transferable practice and learning that may be of use to others when implementing health and other related development programmes in resource restricted settings.

Chapter 2: Terms of Reference / Objectives and Literature Review

This is a focused research project looking at the experiences of individuals participating in or related to either the COHSASA Quality Improvement and Accreditation Programme or the MSH Leadership Development Programme or their combined presentation.

Aim of the research:

The aim of the research is to assess whether there was benefit to the client in integrating the MSH Leadership Development Programme and the COHSASA Quality Improvement and Accreditation programme.

Objectives of the research:

To assess whether the inputs of both parties at the beginning of the programme led to any integration of the delivery of their inputs.

To consider whether the integrated programme delivered any change in terms of adoption by the recipient organisations.

To evaluate if there was a collaborative action plan for implementation support from both COHSASA and MSH.

To assess whether the use of the Leadership and Management practices assessment tools lead to a better compliance with the management and leadership standards in the service elements and the facility as a whole. (The service elements are the groupings of the standards for each department in the hospital, for example the Surgical Service Element would include all wards in the surgical department).

The two overall research questions for the project are set out below:

1. 'Was there any benefit in the integration of the MSH Leadership Development Programme with the COHSASA Quality Improvement and Accreditation programme?
2. 'As a result of the integration of the two programmes, has there been any greater improvement in compliance with the COHSASA healthcare facility standards than would be expected when the COHSASA programme is delivered independently?'

This study used a mixed methods approach in order to explore how a small selection of participants experienced two existing development programmes, which for the first time were combined. The project looked at the key factors or competencies required by leaders in a hospital setting, as set out in the LDP and how these needed to be used appropriately in a specific context to ensure change and improvement were led well and could be sustained. This project aimed to explore first how well the two programmes were brought together and if they were integrated effectively; and second to explore if the implementation of the LDP with the quality improvement programme could be demonstrated to impact on the improvements in the COHSASA standards compliance scores, which indicate that the staff are complying with good practice and required behaviours. It has been found that leadership development and training needs be done in such a way as to enable the individual and team members to put their learning into the context of their work and delivery strategies and to develop followership to build in sustainability.

The project enabled me to review the practical application of specific tools, to assess the impact of participative interventions and to evaluate the success or failure of such approaches to leadership development and its impact on sustained quality improvement in healthcare. It was a concern that many see leadership development as a fad or fashion that will soon pass and be replaced by some other new management technique or style. In the paper 'Leadership for Healthcare', Hartley and Bennington stated, *'leadership is currently highlighted as one of the fashionable solutions to the complex challenges of healthcare'* (Hartley and Bennington, 2010: p 4). This rather undermines two of the thought leaders of the modern quality movement W E Deming and J Juran, who emphasised the importance of leadership in organisations trying to improve quality. Deming was a statistician who went to Japan after World War II and taught leaders of major Japanese companies like Toyota and Sony about statistical process control to improve quality and increase productivity. Juran published his "Quality Control Handbook" in 1951, which lead him to be invited to Japan where he trained top and middle managers in companies like Nippon Kogaku on quality management. He also lectured on the subject in Japanese universities (see for example Deming 1986, Juran 1989). Although subsequently relatively little research had been done on looking systematically at the relationship between leadership and quality. Øvretveit in his literature review noted that no studies have rigorously tested the proposition that leaders are the main influence on improvements in healthcare (Øvretveit 2010). From experience, I believe that good leadership in healthcare is essential and it needs to be developed in a way that enables the healthcare workers at all levels of a system to deal with the complex challenges.

Bradley and Alimo-Metcalfe noted in an article on health care leadership that research has found that people in many different positions lead improvement, not just formal leaders (Bradley & Alimo-Metcalfe 2008). A realist case study carried out at a district hospital in Ghana noted that,

‘The hospital management team, by triggering mechanisms of staff participation, empowerment and reciprocity instigated a U turn in hospital performance’. (Marchal et al 2010, page 15).

This experience is supported by Øvretveit’s observation that “*What a leader can achieve depends in part on the context created by higher-level leaders*”. (Øvretveit 2010; page 492). The senior leadership in these examples are demonstrating transformational leadership, necessary for change. I also agree with Waldman in his assertion that:

“More transactional forms of leadership may be both possible and important at lower levels to ensure that operational quality activities and goals are communicated, monitored, and rewarded”. (Waldman et al 1998, page 177).

I have worked with the COHSASA healthcare facility Quality Improvement and Accreditation programme for eleven years. During that time, the healthcare facilities where the management teams have given leadership and been actively involved from the outset of the programme, have made better progress towards compliance with the standards. While there was agreement that good leadership was essential in providing and improving the quality of healthcare to patients, not much specific research was done on this within COHSASA. The progress towards standards compliance was tracked and compared between three different groups of facilities (COHSASA 2008 unpublished). This indicated that the progress was slower and the scores lower where there was less active management and leadership (See Figure 2)

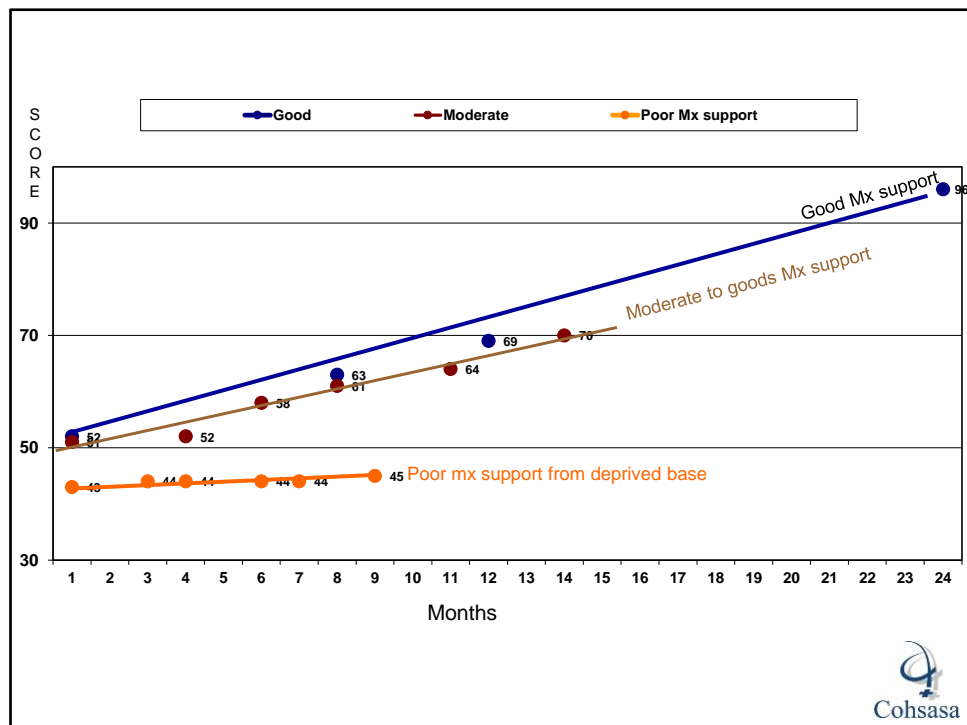


Figure 2 (COHSASA 2008, unpublished) Showing the Impact of leadership and management on the progression of the standards compliance scores

In a paper presented to the annual international ISQua conference in 2016 on public and private sector hospitals in South Africa that have achieved COHSASA accreditation, Ramjee *et al* showed the difference between accreditation scores achieved across different categories of hospitals in South Africa. See Figure 3 below.

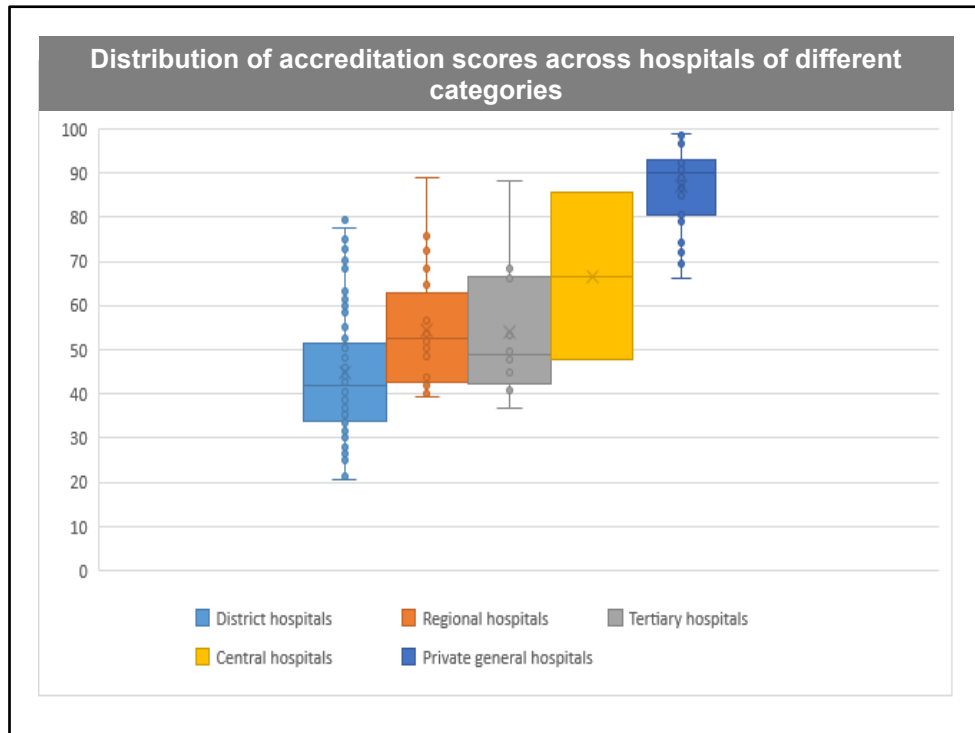


Figure 3 (Ramjee 2016: Slide 13 of presentation. Unpublished) showing the distribution of accreditation scores across public and private hospitals in South Africa

Ramjee noted that,

“the private sector hospitals in the study belong to one major hospital group. This points to a consistency in leadership, management, systems and incentives.” (Ramjee, October 2016, ISQua Conference, Tokyo, Japan)

The same could not be said about the public sector hospitals. The paper went on to state,

“The wide range of public sector scores points to a variety of challenges across regions and levels of hospitals – not least of which are resource challenges.” (Ramjee et al, 2016. Unpublished)

The researchers noted the absence of comparable, published quality measures in either the public or private sectors of South Africa. They cited Day *et al* (2016) who looked at a variety of indicators that address the perceived quality of services for patients. They also cited Allanson et al (2015) who showed that there were many avoidable maternal deaths in the public sector, with an increasing proportion associated with negligence and poor skills.

I wished to examine the practical application of a leadership development programme on the implementation of the quality improvement and accreditation programme and assess the real impact on the stakeholders. In the case of this programme the

stakeholders were the health care workers within the hospitals and clinics enrolled in the programme, which was a cross section of all the groups working in a healthcare facility and included professional medical and clinical staff, allied health professions, technical, administrative, clerical and support staff. There were also key stakeholders within the Ministry of Health who were responsible for providing direction, guidance and oversight to the programme and who, ultimately would be responsible for the ongoing monitoring of the programme.

The programme of work carried out by COHSASA and MSH was reviewed. The focus was to evaluate how well the two programmes integrated in terms of delivering a combined leadership and quality programme. The two programmes have been run independently over the years. COHSASA has been delivering the quality improvement and accreditation programmes since 1995, initially in South Africa and then southern Africa and more recently in East and West Africa. It has introduced the programme into 678 healthcare facilities, including public and private hospitals, primary healthcare clinics and hospices across sub Saharan Africa. COHSASA has very few donor-led projects. Predominantly income is earned through winning contracts from open bids or sourcing contracts through direct negotiations with clients. The LDP was developed by MSH in 2005 and has been introduced into health care facilities in countries in sub Saharan Africa, South America and Asia. With MSH being a large, USA-based not-for-profit NGO with global reach (www.msh.org), thousands of healthcare facility staff have been trained on the LDP. The size and global reach of MSH enables it to bid successfully for formal tenders from donors, which often span multiple countries. MSH and COHSASA identified a synergy between the companies, particularly in relation to quality improvement and leadership.

With the implementation of various development and capacity building programmes across Africa, much has been said about the importance of leadership but there has been limited research of this in kind specifically in the African context. One example is cited by Berwick in his paper '*Lessons from developing nations on improving health care*', in which he reviewed improvement programmes in resource poor settings. Berwick notes

"The opportunity costs for leaders, especially in sub-Saharan countries, who devote their time to improvement are large because the pool of skilled, mature system level leaders is extremely small". (Berwick, 2004: page 1128).

He concludes that, *“A leadership development strategy is an inescapable part of any hopeful plan for improvement of care in developing nations”*. (Berwick, 2004: page 1128).

This has certainly been my experience; that the numbers of leaders are few and as in the example given by Berwick in which he states, *“Politics really does matter, and the effects of political change cannot always be mitigated”* (Berwick, 2004: page 1127) when political change results in the loss or redeployment of key leaders of a project or programme.

Blackler and Kennedy were commissioned to develop a leadership programme for senior chief executives in the English NHS in 1999, at a time when the NHS was under huge political pressure to improve and undergoing politically driven reforms. The authors observed *“the heavy demands that shifts in complex activity systems can make on those involved”* (Blackler and Kennedy, 2004: page 197) and found that there *“was little consensus about appropriate approaches for leadership development in the public sector”* (Blackler and Kennedy, 2004: page 181). They went on to devise a programme for public sector leaders at Lancaster University based on three levels of leadership, the self, organisation and context.

Around the same time that Blackler and Kennedy were developing the leadership programme for senior chief executives, the NHS Leadership Centre commissioned research into the qualities of leadership in the NHS. The research was done with 150 Chief Executives and very senior managers and resulted in the development of the NHS Leadership Qualities Framework (2002). A 360-degree assessment tool (LQF 360 tool) was developed based on the Framework to identify the leadership competencies at various levels in NHS organisations. While the framework and tool do not identify specific competencies required to lead quality improvement initiatives, within the area of personal qualities, there is ‘drive for improvement’ and within the area of delivering the service, there is ‘leading change through people’, both of which could be seen as competencies for leading improvement. In 2010, the NHS Institute for Innovation and Improvement commissioned KM Research and Consultancy to undertake an evaluation of the impact the LQF 360 tool had on the individual, the organisation and the wider NHS. The evaluation found that the tool commands widespread support in the NHS and there is firm evidence of its beneficial impact.

In the UK Government’s Cabinet Office publication, it was stated:

“There are many leadership development initiatives, and new leadership colleges are being set up. But there is little evidence so far as to their

effectiveness". "There is little shared understanding of the qualities required for effective leadership in today's public services. (Strengthening Leadership in the Public Sector; Performance and Innovation Unit: 2001).

One has to question whether some politicians and researchers are seeking the 'holy grail' for a unique set of leadership qualities for public sector and more particularly, healthcare settings.

Alimo-Metcalfe and Alban-Metcalfe cite the Cabinet Office paper in their research *"to develop a wholly new model of transformational leadership"* (2006: page 294), which seemed somewhat counter to the point made regarding the plethora of leadership development initiatives. Nonetheless the authors raise interesting concerns about the validity of the U.S models to the individuals working in the UK public sector organisations. This raises the question that if methods may not be valid between two western, first-world countries, how valid are such methods for use in resource restricted and emerging market countries?

From the research the authors developed the Transformational Leadership Questionnaire (TLQ), a 360-degree assessment instrument, which was piloted in NHS and local government organisations. Many of the dimensions are similar to those in the NHS LQF 360 tool and yet Alimo-Metcalfe does not reference the LQF once in the paper.

In light of the concerns raised by Alimo-Metcalfe in relation to the validity of U.S models in the UK, I looked at the work of Hofstede. The Hofstede model (Hofstede & Hofstede 2005) distinguishes cultures according to five dimensions: power distance, individualism/collectivism, masculinity/femininity, uncertainty avoidance, and long/short-term orientation. The model provides scales for 76 countries and was widely accepted as the model of choice for organisations looking to operate in different countries and therefore somewhat answered the question posed by Alimo-Metcalfe. However, Jackson challenged Hofstede and other researchers who define cultures by nation, group or organisation and proposed that cultural interfaces are more important. He argued that,

"their individual "subject" represents not a "culture" but the confluence of a complex and multi-layered interface that can only be accessed through the agency of individual's cultural identity but can only really be understood through an analysis of the cultural interfaces involved". (Jackson 2011: page 541)

Jackson also noted the lack of studies carried out by cross-cultural management scholars in the developing world, similar to the dearth of literature on quality and leadership in Africa.

It is interesting that the LDP was developed in 2002 by MSH in Aswan, Egypt. The leadership dimensions of the leading and managing practices within the LDP are similar to those in the in both the TQF and NHS LQF, albeit in simpler terminology. The questionnaires are framed to the level of the organisation and to the level of the individual. Subsequently the programme was supported by a hand book, 'Managers Who Lead. A Handbook for Improving Health Services' (Galer et al, 2005). This popular publication was translated into Arabic, French and Spanish. The LDP and the questionnaires (Appendix 2) have been used in 40 different countries, which may indicate that attention was given to the cultural interfaces to ensure the programme is sensitive and applicable in many settings, especially in developing countries.

A lot of work has been done in the UK and Europe, particularly in the field of nursing on culture and leadership. Papadopoulos and her colleagues created the Papadopoulos, Tilki and Taylor Model for Developing Cultural Competence. They say,

"Teaching and guiding skills can also be used in providing clinical and professional leadership to staff, enabling them to develop cultural competence" (Papadopoulos et al; 1998, page 146).

In her theory of cultural competence, Magee states, *"Cultural competence is an evolving state, a continuous process of learning, performing and reflecting"* (Magee; 2009, page 150). These works demonstrate that cultural competence can be learned through developing cultural knowledge, sensitivity and awareness.

Vaughan et al (2006) conducted a survey of hospital chief executives and senior quality executives from a sample of hospitals to identify the characteristics of hospital leadership engagement in quality improvement that were most likely to strengthen quality improvement activities within hospitals. The survey found that better quality index scores were found where the hospital board spent more than 25% of their time on quality issues and received regular reports on quality performance measurement. It also found that better scores were achieved if executives' compensation was related to quality performance and if there was a high level of interaction with medical staff on quality strategies. This supports the experience that COHSASA has demonstrated that hospitals achieve greater compliance with the standards where there is active and visible involvement in the quality improvement and accreditation programme by the hospital management team. See Figure 2 on page 16.

Kaplan concluded that:

“Several contextual factors were shown to be important to QI (Quality Improvement) success, although the current body of literature lacks adequate definitions and is characterized by considerable variability in how contextual factors are measured across studies”. (Kaplan et al, 2010: page 500).

In 22 of the 47 studies reviewed at least one aspect of leadership was examined. Leadership of top management and governing bodies were two of the most frequently studied. The overall finding was a positive association between top management leadership and quality improvement success.

“Our review also revealed that much of the current research suffers from conceptual ambiguity and methodological weaknesses. Accordingly, we cannot make definitive conclusions about the influence of particular contextual factors in QI success and the aspects of context that we have identified as related to QI success should be studied further” (Kaplan et al 2006, page 521).

To some extent the Health Foundation in the U.K addressed the suggestion of Kaplan, when it commissioned a study to explore specifically the links between leadership and quality improvement (QI). In the study ‘What’s leadership got to do with it’, the researchers were looking at participants on a number of development programmes related to many different quality improvement activities. The three core enquiry questions for the study were:

1. *What are the links between QI and leadership behaviour?*
2. *Do different types of QI require different leadership behaviours?*
3. *What are the lessons for leadership development generally and for the Health Foundation specifically? (Flanagan et al, 2011:23)*

The findings of the study included that:

“Engagement and relationship skills are fundamentally important in leading improvement... more than task-related or conceptual skills”. (Flanagan et al, 2011: page 70)

While the Health Foundation looked specifically at the leadership characteristics and behaviours that impact on different types of quality improvement activities, it did acknowledge the range of contributing factors related to quality improvement. Kaplan noted: *‘The presence of data systems was positively associated with QI success’* (Kaplan et al, 2010: page 517).

Talib undertook a literature review to identify a set of total quality management practices that could be used by the researchers and practitioners of healthcare institutions for its successful implementation. It was an interesting study as the researchers were engineers with no direct connection with the health care sector. Also it was conducted in India, which has more resonance with Africa being an emerging market. Their findings included that:

‘top management commitment and support (leadership) is found to be the most important enabling practice for implementing TQM in healthcare institutions’.
(Talib et al: 2011, page 242).

In a study in Lebanese hospitals to assess the perceived impact of accreditation on quality of care through the lens of health care professionals, specifically nurses. The study revealed that,

“The model indicated that the predictors of better quality results were leadership, commitment and support and use of data respectively”. (El-Jardali: 2008, page 366).

An Australian blinded, random, stratified study with the aim of determining the association of accreditation survey scores with clinical and organisational performance, found that accreditation performance was significantly positively correlated with organisational culture and leadership.

“Some organisational variables were significantly related to each other, specifically organisational culture with leadership and organisational climate, and clinical performance with leadership”. (Braithwaite: 2010, page 18).

In an article talking about the role of the LDP in assisting with the challenges of human resources for health O’Neil made a pragmatic statement,

“One imperative for all countries, however, is the leadership and management capabilities to translate HR strategies into systems and practice that result in sustainable improvements”. (O’Neil, 2008).

This underpinned the opportunity to combine the programmes.

COHSASA developed sets of health care facility standards for a range of health care facilities including hospitals, primary health clinics, hospice and palliative care services, sub-acute facilities and environmental health services. The standards compliance data is recorded after each evaluation at a health care facility. In the early days of the programme this was into an Access database. A web-based system was

then developed which enables the data to be captured and maintain an historical record of each evaluation. The system is now available in the client organisations to enable them to carry out self-evaluation of standards compliance and capture the data, which can then be reviewed remotely.

The information system was a key factor in the proposal to bring together the two programmes. The LDP starts, after initial training, with the facility staff identifying the problems that they need to address in the programme. There might have been very good reasons for a situation being selected, but generally the selection was subjective and anecdotal. The baseline survey carried out by COHSASA, provided an accurate, objective evaluation of compliance with the standards and enabled interventions to be prioritised according to the potential impact on patient or staff safety, legal compliance or efficiency.

Research on the COHSASA programme, carried out by the Quality Assurance Project of the University Research Company for the United States Agency for International Development found that:

“intervention hospitals improved their average overall scores from 48 percent to 78 percent, whereas control hospitals maintained the same score throughout (43 percent)”. (Salmon et al: 2003, page 15)

That research and further experience showed that while compliance with the standards could be demonstrated, which in itself created improvement in the systems and processes in a facility, there was little evidence that indicators relating to health outcomes and patient satisfaction were improved. This has been an ongoing challenge for the accreditation programme, demonstrating that it adds value and can benefit the patient through improved clinical outcomes.

In a study carried out to validate perinatal care indicators by an independent means of assessing quality of care, Pattinson and Whittaker (2007) demonstrated that there was a negative significant correlation between the COHSASA standards score for the overall hospital and the maternity services and the perinatal mortality rate and other perinatal care indices.

Linegar described a study in which they looked at the influence of the quality improvement and accreditation process on service quality and on postgraduate training programmes;

‘The study illustrates the positive influence of the accreditation process on the quality of clinical service delivery and, in consequence, on post graduate training standards’. (Linegar: 2012, page 146).

In conclusion the authors stated,

“While a facility may not achieve full accreditation at its first evaluation, it is the process of correcting identified deficiencies that brings about the important changes in the organisation. These changes concern the development of a culture of quality improvement in service delivery at all levels of the healthcare facility. Quality improvement in service delivery to patients and the community, and in the working conditions of the healthcare providers, is the ultimate goal of the accreditation process”. (Linegar: page 148).

None of the research into the COHSASA accreditation programme has looked at the role of leadership specifically. However, the experience of running the programme for nearly 20 years has shown that where leadership is strong, the programme is implemented more effectively. Where leadership is weak, the facilities struggle to achieve full accreditation (See Figure 2 on page 11). It was this experience and the good relationships that developed during the SA-HCD coalition that led to the decision to pilot the joint programme.

Bahamon reviewed the experience of MSH in developing the LDP, which identified that leadership development was more focused when related to a specific challenge. When motivated individuals began to work with the challenge, they could bring others on board.

‘Early in the change process, this person reaches an agreement with others on this challenge and becomes the change agent involving others in creating a vision of a better future that generates commitment’ (Bahamon et al 2006 page 659).

It has been demonstrated to work effectively in a variety of healthcare settings across the world. To date there has been little research into the way the programme is delivered and how appropriate or effective is it in sustaining a positive impact on the facilities into which it is introduced.

It may be that the programme focuses on management and leadership development and has not considered the concept of followership. Kelley (1992) describes the different followership styles and how these can positively or negatively affect the organisation. There are five dimensions and style, the first are those who are

dependent and do not think critically – they may be either passive or active – that is passive followers, who need to be motivated and directed; or active, conformist followers, who support the leader and are motivated but do not act without instruction. Those who can apply critical thinking and act independently may also be passive – alienated followers, who argue with the leader and are often sceptical. The exemplary follower will argue constructively if they disagree and will support the leader fully. In between is the pragmatic follower, who will sit on the fence in terms of thinking, but will generally support whatever needs to be done. He also describes how individuals can recognise their own followership style and learn to change to become exemplary followers. Grint gives the description, *“Followership is the anvil of leadership, the former can make or break the latter”*. (Grint et al 2011. Page 7).

Morton undertook a study to look at the influence of followership styles on organisational commitment. They cited Allen and Meyer’s (1991) model of organisational commitment, which offers three components: affective, continuance and normative. The first is a strong emotional identification with the organisation; the second, a need to stay for financial reasons and the third, the obligation of the individual to the organisation. They state, *“the present study found that exemplary followers are more likely to have an affective organizational commitment”*. (Morton et al 2011. Page 36).

Summary and conclusions

The literature reviewed in this chapter is only a sample of what is available in relation to research on leadership and quality. I was particularly interested in those publications that investigated the link between leadership and quality and it was salutary to note Øvretveit’s findings in his literature review in which he noted, *“that no studies have rigorously tested the proposition that leaders are the main influence on improvements in healthcare”*, (Øvretveit 2010, page 491). My research question, if there was any benefit to integrating the MSH LDP programme with the COHSASA programme, may go some way to indicating there could be some influence of leadership on quality.

Much of the research has looked at leadership at the higher levels within organisations. It was interesting that Bradley and Alimo-Metcalfe’s research has found that people in many different positions lead improvement, not just formal leaders (Bradley 2008). The paper by Marchal, one of the limited number that I found specifically on research in Africa, found that if management enable staff participation and empowerment, hospital performance improved (Marchal 2010). This was an important element for me to

consider in my research, given Berwick's findings, "*that the pool of skilled, system level leaders is small*", (Berwick 2004: p 1128), can those in lower positions be empowered to lead improvement? COHSASA's own internal research on the performance of facilities with differing levels of involvement of the top management and leadership, indicated that there could be an impact. The influence of followership is an important consideration and while it is beyond the scope of this study, its impact on organisational commitment could be a factor to consider in the sustainability of the programme going forward.

There was also the influence of culture, which was explored by Papadopoulos et al (1998) and McGee (2009). Linegar also referred to a culture of quality that developed at all levels (2012). Finally, I looked at the data that was generated and used during the programme to test if this supported the findings of Kaplan (2010), that the presence of data systems was positively associated with quality improvement success.

Chapter 3: Design and Methodology

Introduction

The purpose of the research was to explore if there was a benefit to participants of introducing a leadership development programme simultaneously with a quality improvement and accreditation programme. The main focus of the study was to sample the experiences of those involved from the two organisations, the Ministry of Health and participants in one hospital. COHSASA has developed internationally accredited healthcare facility quality standards and it is compliance with these standards that indicates an improvement in the quality of the services. I considered a number of research approaches to best answer the research questions:

Research questions:

1. 'Was there any benefit in the integration of the MSH Leadership Development Programme with the COHSASA Quality Improvement and Accreditation programme?
2. 'As a result of the integration of the two programmes, has there been any greater improvement in compliance with the COHSASA healthcare facility standards than would be expected when the COHSASA programme is delivered independently?'

Methodological approach

In her paper in the journal, *Qualitative Health Research*, Morse suggested that researchers investigate widely to ensure the research methods selected are the best to elicit the results relevant to the context.

'one's research methods should be made cautiously and consciously from a broad range of methodological options with the context of the nature of the type of results desired or knowledge sought'. (Morse 1999 page 393)

Crotty proposes a logical process for decision making in deciding upon a research approach. He suggests that researchers should be able to answer four questions, which he defines as the basic elements of any research process. His questions are:

1. What *methods* do we propose to use? (Data collection and analysis)
2. What *methodology* governs our choice of methods? (Design, plan)

3. What is our *theoretical perspective*? (The philosophical stance informing the methodology and providing context for the process)
4. What *epistemology* informs our perspective? (What is the theory of knowledge embedded in the theoretical perspective and thereby in the methodology)

The questions do offer a framework for the various decisions that have to be made when designing research. Creswell (2003) gives the opinion that the questions inform a choice of approach that encompasses broad assumptions from practical considerations to data collection. Crotty states that a broad structured approach helps researchers to make sense of the vast amount of research approaches that exist. He proposes that epistemology, theoretical perspective, methodology and methods are elements that are all reliant on each other.

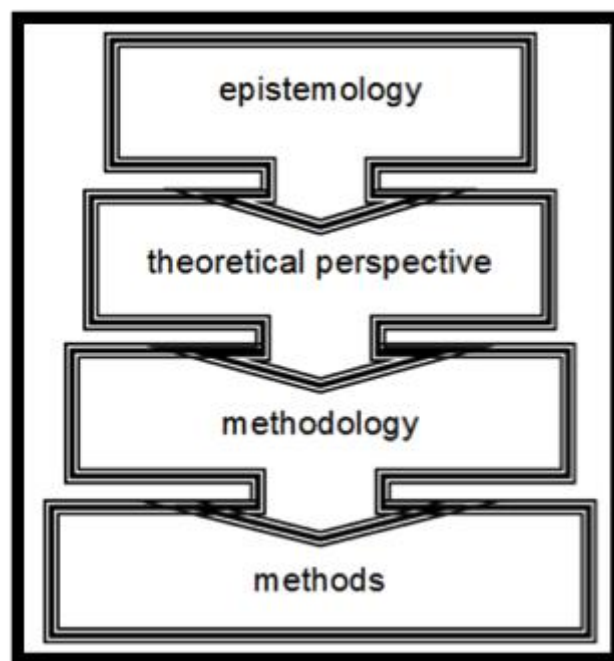


Figure 4 - copyright of M. Crotty (1998) page 3

Plowright in his book 'Using Mixed Methods' makes the case for a more holistic approach to research and introduces the model Frameworks for an Integrated Methodology (FralM) that enables researchers '*to take a fresh look at the way we think about social and educational research*' (Plowright 2011:3). The model allows a researcher to use a framework that is seen as a 'basic structure' to fill with content suitable to the specific project. The starting point is the research question, which is set within a particular context. Plowright offers five contexts, professional, organisational, policy, national and theoretical.

The COHSASA accreditation standards include measurable criteria which are scored to indicate the level of compliance and therefore a quantitative approach seemed the most obvious to adopt. The level of compliance could be mapped against the leadership interventions to assess if there was a relationship. However, this was the first time the two programmes had been brought together and the process of developing a combined programme, proved to be quite difficult, with little agreement of the key indicators. There were many variables that could impact on the programme that could not be controlled. To have used a purely quantitative approach would have required having control hospitals where the programmes were introduced separately in order to demonstrate the difference, if any in the performance of the control and intervention sites.

I considered Crotty's pyramid approach; he talks of three epistemologies, objectivism, subjectivism and constructionism. In relation to constructionism he says, *"In this understanding of knowledge it is clear that different people may construct meaning in different ways, even in relation to the same phenomenon"* (Crotty, 1998. Page 8). This epistemology seems appropriate for the study as it relates to people in different organisations involved in the same phenomenon.

Plowright's FraIM (2011) offered the opportunity to place the research questions into the contexts. Being a healthcare environment, the professional context was important and it provided the possibility of assessing differences between professional groups. Given the participants were from different organisations, this context was also important and would enable some view of the organisational cultures. I believe that the professional and organisational contexts would also assist me to be very clear about my relationship with the various participants and my previous experience and involvement with the programme.

I considered the role of the practitioner researcher as described by Fox, in which they state that,

"Practitioner researchers should be prepared to place themselves outside practice, in order to understand the propositional knowledge driving practice within the research field". (Fox et al, 2007; page 40)

I also considered the participant-observer relationship described by Vinten and the effect this role could have on the research,

"There is an inevitable trade-off between the insider status and the reduced level of statistical reliability that is achieved". (Vinten, 1994; page 31)

Consideration was given to a qualitative approach using case study as the research is exploring a programme and process that is bounded by time and activity (Stake 1995). This method requires a variety of data collection over a sustained period of time. On reflection however, I felt that the scope of the study does not lend itself to case study and this could miss the essence of what the research is seeking to establish – that is the benefit to the participants and the overall success or not of combining the programmes.

I did not see the approaches by Crotty and Plowright to be mutually exclusive and both could assist in guiding and giving structure to the research. Within the contexts of Plowright's FraIM, a mixed methods approach fitted well in order to explore how a small selection of participants experienced two existing programmes, which for the first time had been combined. The reason for this decision was helped by reading Creswell, in which he cites Fraenkel and Wallen (1990) who stated,

“the intent of ethnographic research is to obtain a holistic picture of the subject of study with emphasis on portraying the everyday experiences of individuals” (Creswell, 2003: Page 200).

This resonated with the intention of the study to explore the process of how the two programmes had come together and if this combination had been effective. There were different perspectives and hence the holistic picture was important. This also seemed to fit comfortably with reflective practice, which I believed would help me in categorising the data.

“It is the twin aspects of uncovering a multi-layered reality from the subject's point of view and with the researcher participating in the organisation that connects ethnography and reflective practice both with each other and work based learning”. (Costley 2010. Section 9.3)

The two programmes were the COHSASA Quality Improvement and Accreditation Programme and the MSH Leadership Development Programme. The organisations responsible for delivering these two programmes anticipated that by combining the programmes' delivery, rather than delivering separately, would result in a benefit in terms of learning and development in both quality improvement and leadership methods for the participants and an overall improvement in the compliance with the COHSASA quality standards.

Data collection methods

Semi-structured interviews, with pre-set questions were used on the small study sample of participants drawn from the stakeholder organisations of COHSASA, MSH, the Ministry of Health and one selected hospital, which was implementing the combined programme, in order to understand their perception and experience of undertaking the combined programmes. The interviews were mostly conducted by telephone or Skype. The interviews were recorded and then transcribed to ensure completeness in the capturing of the information. The transcripts were shared with the participants to check for factual accuracy. Secondary statistical evaluation data which was collected by MSH and COHSASA provided a before and after baseline to indicate any perceived improvement in the leadership skills and an improvement in the quality improvement processes, indicated by the scores achieved for compliance with the standards. However, this study was more concerned with the experience of the participants. Consideration was also given to identify opportunities for possible areas for change and improvement in either or both of the programmes and how this could be effected between MSH and COHSASA.

Sampling strategy

The sample size was small as the participants from MSH and COHSASA were selected from the facilitators that were involved in bringing together the programmes and facilitating the implementation. The participants from these two organisations had experience of running the original independent programmes and worked together on the new joint programme. There were only two members of the COHSASA team directly involved in the process, besides the managing director (retired) and me. Similarly, there were two key personnel from MSH that were directly involved in the development of the programme and the implementation.

The participants from the Ministry of Health were selected for their knowledge and involvement with the programmes. They were one senior officer with previous experience of the COHSASA programme, a senior officer with previous experience of the LDP programme and a senior officer with experience of the joint programme. They were all involved in the new, joint programme. The participants from the hospital were selected to give a cross sectional view and insight into the essence of the experience of the programme at different levels in the organisation. The participants in the hospital only had experience of the integrated programme. A key criterion in selecting the hospital staff was to ensure they were in post at the start of the programme and thus experienced all the related training, including the leading and managing practices

training related to selecting the priority areas for the early quality improvement projects and the standards interpretation training. The total number of participants was ten. Although the sample size was small, it was important that the participants all had direct experience of the programme from the start. The respondents were stratified according to the organisation for which they worked. This was done to assess the perspective of the 'providers' of the programme and the 'recipients' of the programme and also to elicit any nuances from participants in the different organisations.

Demographic information

The study sample of participants was drawn from the stakeholder organisations of COHSASA, MSH, the Ministry of Health and one selected hospital. This provided a cross section of views about the introduction and impact of the programmes. The participants were all healthcare professionals except one person, who had an MSc in Geography and MSc in Geographical information systems. There were three doctors, three nurses, one pharmacist, and one occupational therapist. Four were males and five females. The age bands of the respondents were: 60+, one; 51 – 60, three; 41 – 50, four and 31 – 40, one. A detailed breakdown of participant demographic details is shown in table 2, p.37.

Analysis of Data

The information gained from the semi structured interviews was analysed thematically to understand some of the complexity in data collected. The first step in this was at the point of data collection, during the second interview I noticed some common factors were raised by the interviewees. The tone of voice and passion of the interviewees about certain topics also indicated that they had very positive or very negative feelings on some specific areas. Again, some of these were common to a number of the interviewees. I began to note these and reviewed them again when transcribing the interviews. I initially followed the six-point approach of Braun and Clarke (2006), set out in the box below.

Phase 1: Familiarising yourself with your data

Phase 2: Generating initial codes

Phase 3: Searching for themes

Phase 4: Reviewing your themes

Phase 5: Defining and naming themes

Phase 6: Producing the report

All the interview transcripts were read and reread and initial codes identified. I did a word search of all the scripts to see if common words would indicate codes. This was not particularly helpful and the words needed to be in context to be part of a theme. The individual scripts were annotated with codes that began to emerge. I then grouped the scripts by the origin of the interviewees, that is hospital, Ministry of Health and COHSASA and MSH as the implementing partners, this allowed common codes to be identified – and any that were unique to the individual. Whilst Braun and Clarke, in their approach to thematic analysis, advise against slavish adherence to the interview questions as this could lead the researcher into finding what they want to find, the emerging themes were, for the most part, in line with the questions.

I reviewed the transcripts again following the eight-step approach proposed by Tesch (1990: page 142 - 145) within the three groups and then across all transcripts. I identified twenty-three categories and then grouped these into themes using a mind map. Six themes were identified using this method.

This was supplemented by an overview of the MSH evaluation questionnaires that were completed by participants, their supervisors and direct reports, which indicate perceived improvement in leadership behaviours; and the standard compliance data. The MSH questionnaires were completed at the beginning of the programme and some after six months. Unfortunately, I did not have access to any of the completed questionnaires and was only able to look at the questions that were asked and the feedback that participants made during the interview.

When the quality improvement projects started to be implemented, the departmental leads reassessed the compliance with the quality standards. This self-assessment data was captured into the web-based COHSASA information system, CoQIS every eight weeks and provided a continuous record of the progress. The self-assessment

data was validated by on-site visits carried out by the QIL support team (COHSASA, MSH and Ministry of Health). During the visits, the team reviewed the evidence provided to support the compliance rating. This enabled the self-assessment to be validated as correct or amended and advice given as to how to improve the situation further. There was three years of evaluation data available for access as part of this study.

This secondary statistical evaluation data which was collected by the organisations provided a before and after baseline to indicate any improvement in learning outcomes assessment in relation to leadership and quality methods. Having the data from the semi-structured interviews and the standards compliance enabled the qualitative and quantitative data to be reviewed. Unfortunately, due to the funding of the programme coming to an end, the data capture and analysis of the leadership questionnaires did not take place.

The study was concerned with the experience of the participants and how well the programmes came together. There was also the possibility of identifying areas for change and improvement to either or both of the programmes, should these have been seen as beneficial to MSH or COHSASA, and ultimately to clients and health care systems.

I was aware that the findings may indicate that the two programmes did not deliver additional benefit by being delivered together as a combined programme. The two organisations have historically delivered the programmes separately with reported success and therefore this will not be a major problem for other areas. However, if this was the case, it could have had implications for the work with the current client. The Ministry of Health had been involved from the outset of the joint programme and there was funding from the United States Agency for International Development (USAID) for the joint programme. The different cultures of the organisations perhaps play a part – there were three organisations taking part in the programme, with sub-cultures in each of the hospitals and clinics.

I was also aware that carrying out interviews with individual staff members could uncover dissatisfaction or dissent towards programmes. The interviewees were all anonymised in the event that they disclosed any information that indicated the reported data in the programme might not be accurate. While this was unlikely as the data in the CoQIS system is validated periodically, the research was primarily to look at the success of bringing the programmes together, not the performance of the actual

hospital in relation to the standards and leadership development. This would fall outside the scope of this MProf project and may be the focus of future research.

The study sample was quite small and therefore a pilot study was not undertaken, other than to pilot the questionnaires that were used in the semi-structured interviews.

Ethical issues in this research

The participants were assured of confidentiality of all information disclosed during the interviews. This was vital to ensure that the results of the research were reliable and gave an accurate assessment of how effective was the combining of the programmes. The reliability of the results is needed to contribute to the knowledge on leadership development and quality improvement in the African context.

I was very much an 'insider' on this programme. I am now the CEO of COHSASA. In my previous role of Chief Operations manager, I was the key liaison person with the client and was involved in the discussions and decisions to bring together the two programmes. The advantage of this position was that I had detailed knowledge and insight into the COHSASA programme and how it operated, including the standards compliance data collection, analysis and interpretation. I was also familiar with the MSH LDP programme and was instrumental in the proposal to bring the two programmes together. I had developed excellent working relationships with officials of the Ministry of Health in Botswana, which assisted in gaining access to interviewees, subject to all the required permissions. There were also good relationships with the MSH personnel, which have been maintained, although subsequently the two organisations have not identified joint projects to work on.

In his work on the participant observer Vinten states, '*The participant observer will be an intimate part of the very sinews and tissues of the organisation being researched*' (Vinten, 1994: page 30). While this was true for my own organisation, I had less intimate knowledge of the others involved. However, if I substitute 'programme' for 'organisation' as there were the two implementing organisations, MSH and COHSASA and the recipient organisations, the MOH and hospitals, involved in the programme, I can then identify with the classification of research roles Vinten cited, '*Researcher as employee; research as an explicit role, interrupted involvement; and observation*'. (Easterby-Smith et al 1991). I think I was able to use all these roles to some extent during the life of the programme, combining the 'researcher as employee' with the 'research as an explicit role' during the actual research and data gathering. These allowed me to operate effectively as a participant researcher across the programme. This changed my initial thinking that I needed to make explicit to the interviewees that

the research was being undertaken in my personal capacity and not as an employee. Fox et al (2007) use the term practitioner researcher and again this is a concept that resonates as a practitioner of quality improvement within the COHSASA programme.

This disadvantage of this familiarity was that I needed to be exceptionally careful to ensure that no personal bias was allowed to influence the research. As a participant researcher, I had to ensure therefore, that any critical statements about the company, the development programme or indeed any of its employees were received and dealt with objectively as part of the research. Similarly, any observations on the LDP or MSH were dealt with in the same manner. Nonetheless, it was difficult for the participants to see me as independent, given my position in the company. A paper that assisted my thinking on how to approach this was by Gibbs in which he describes the contribution of the participants as a gift to the researcher for which there must be gratitude in return. It further explored the role of the insider researcher,

“the role of the practitioner as an insider researcher occupies a unique place in the continuum of personal relationships between researchers and participants”.
(Gibbs: 2009, page 157)

The concept of gratitude for a gift was helpful and Gibb's assertion that, *“It recognises the autonomy agency of the giver independent of their role and status in an organisation”*. (Gibbs: 2009, page 60) helped me to view the participants as 'outside the organisation for the period of the interviews and the data analysis.

Confidentiality was maintained throughout, with no real names cited in the research reports. All participants were given pseudonyms, along with other measures to ensure that participant identities were protected

As the insider researcher, it was crucial for me to assess the objectivity of all the analysis and findings of the research. Costley talks about discussion on the asymmetrical power relationship of the interview being underdeveloped in the literature. She cites Briggs (2002),

“the interviewer has power of what is said, how it is said, how it is recorded and how it is subsequently represented and encoded as knowledge”.

I ensured the questions were open and enabled the respondents to talk freely, sometimes it was a little off the point, but I did not stop the flow. All the interviews were recorded and the respondents were sent the transcript and given the opportunity to amend it.

I am passionate about quality improvement and leadership as key factors in improving healthcare service delivery and good patient care and as such, saw this small research project as an important demonstration of the necessary objectivity required to make a real difference in the delivery of programmes intended to assist in this.

Summary & conclusions

Having considered the various possible methodological approaches for the research, I decided upon a mixed methods approach. Data collection methods comprised semi-structured interviews to develop a qualitative view of the experiences of the programme by the various participants within their professional and organisational context. There was also an analysis of the secondary statistical evaluation of the standards compliance data and any available data from the LDP questionnaires. A great deal of time was spent considering the ethical implications of the research and particularly my role as an insider researcher. Also of importance was confidentiality and how this would be maintained with a small sample.

In the next chapter I describe the activities required to put the research protocol together and the practical steps required to carry out the project.

Chapter 4: Project Activity

Introduction

The first activity was to seek ethical approval from the Ministry of Health, thereafter from the identified hospital and once these were secured to seek ethical approval from Middlesex University. This process proved to be time consuming. Documents had to be sent via email and then hard copies sent via courier due to unreliable local postal services. The process took more than eight months to complete. Confirmation of the ethical approval from the Ministry of Health and Middlesex University are attached at Appendix eight and nine respectively. The ethical approval from the hospital is not included as it would identify the site and breach the confidentiality agreements made with the participating organisations.

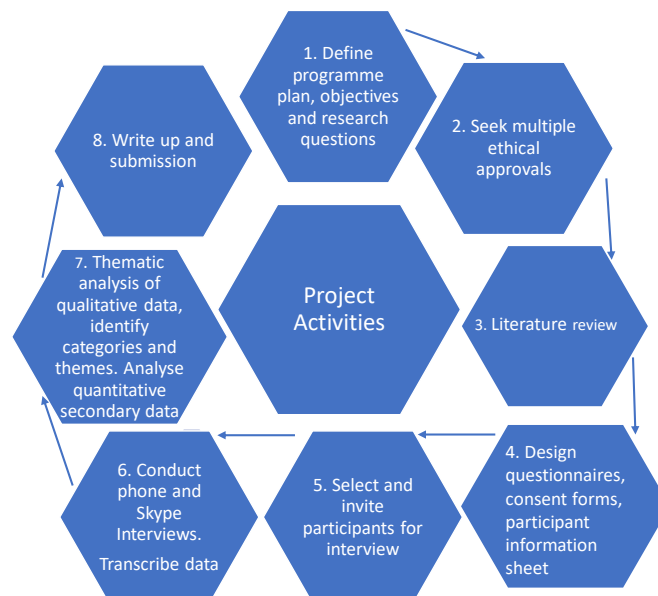


Figure 5: Graphic illustrating the flow of programme activities.

Documentation

Consent forms and participant information sheets were developed in line with the requirements of the university. The participant information sheet clearly set out that the research was looking at how the two programmes had been brought together and not at the performance of a specific hospital or the personnel within the programme. The participants were asked to sign the consent form (Appendix 3) after reading the participant information sheet (Appendix 4) to ensure they were giving informed

consent. They were also informed that they could withdraw from the process at any time. The consent form also included a statement that the interviews would be audio recorded and transcribed.

Questions were developed to enable consistent questioning during the semi-structured interviews (see Appendix 5 and 6). The questions sought to elicit the experience of the respondents during the programme. The questionnaires varied slightly for the MSH and COHSASA staff – the implementing partners and the staff of the Ministry and the hospital. For the first group information was sought on the actual process of bringing the programmes together, developing joint training programmes and implementing the programme. Respondents were asked to identify the benefits and deficits in the programme

For the participants in the programme, questions related to the training that was provided, specifically the content and then how this was applied and shared. These questions were important to find if the training had been perceived as 'joint'. Questions then related to the parts of the programme that the participants believed had been most useful or least useful to them – at the time and subsequently. Participants were then asked to describe the benefits of the programme to the hospital(s).

Pilot study

The questionnaire was piloted on a member of COHSASA staff who had been involved in the programme. There were eight amendments made following the pilot interview; these related to clarity of language and none changed the meaning or intent of the questions.

Interviews

The interviewees were stratified into three groups; those from COHSASA and MSH who were directly involved the development and implementation of the programme; officers from the Ministry of Health who were involved with the implementation of the programme and participants from a hospital where the programme was introduced. This was done to assess the perspective of the 'providers' of the programme and the 'recipients' of the programme and also to elicit any nuances from participants in the different organisations.

I had to seek written permission from the heads of the directorates within the Ministry of Health and the Hospital Superintendent, before I could contact any staff directly. In some cases, this proved to be a time consuming process. Potential interviewees were identified as those who had been involved at the beginning of the programme. Some

had moved to different places of work. There were four potential interviewees at the Ministry of Health and five at the hospital. Three of the four at the ministry responded and were interviewed. Three of the potential five at the hospital responded and were interviewed. Both the two potential interviewees from COHSASA agreed to be interviewed. One had left the company but was interviewed, as he had been closely involved with the programme.

The Building Local Capacity programme run by MSH, within which the development of the QIL programme resided, had been closed at the end of the funding cycle. All three people who had been involved in the programme had moved to other jobs, two to other countries. One could not be contacted despite great efforts. Two responded and agreed to be interviewed. Of these only one finally took part in an interview. The second was contacted for a Skype interview but the connection was poor. He then offered to complete the questionnaire and return it to me. Despite repeated emails and Skype messages confirming this would be done, the questionnaire was never received. In total nine participants took part in the study.

The interviews were all conducted telephonically or via Skype, except one where the participant requested to complete the questionnaire and have this followed up with email or telephonic discussion. All the participants were asked at the beginning of the call to confirm that they agreed to the interview being recorded and transcribed. All agreed to this.

Transcribing the data

I wrote down key points during the interviews, which helped when doing the transcriptions. Some of the interviewees were quite passionate about aspects of the programme and emphasised negatives and positives about the process. This made these points stand out at the time of the interview and during transcription. I tried to do the transcribing immediately after each interview but this was not always possible and some were transcribed a few days after the interview. The transcribing was time consuming and at times quite difficult. Most of the recordings were reasonably clear but some were not because of poor telephone connections, with some interviewees using mobile phones. This meant some of the recordings were difficult to hear in places and some comments were less audible. By using the notes and replaying the section repeatedly, I managed to transcribe the correct words. The interviews were transcribed verbatim and the transcriptions were sent to the participants for confirmation of factual accuracy. One made some corrections to the grammar but confirmed the content was an accurate reflection of the interview. During the

transcribing, I found that I was also noting common areas being spoken of by the interviewees.

Data Analysis

The data was analysed using thematic analysis, which was done in a number of stages. The first stage was noting points that were emphasised by the participants during the interviews; some were quite passionate about the programme and common points were raised by a number of interviewees. Then during the transcription of the interviews similar common themes emerged. Once transcribed, I read and reread all the transcripts several times. I coded categories on each transcript. I then grouped the transcripts by hospital, MOH and MSH / COHSASA. At this point I used NVIVO to do an analysis based on my initial findings. I used the basic programme as I was not familiar with the programme. Based on the selections of text that I made, eleven themes emerged. I also used a word frequency application, while it was interesting, it did not add any value to the thematic analysis process. The initial themes identified were:

Benefits of the programme; Impacts of training; training; sharing training; impact of leadership; quality; challenges within structure; methods and approaches; cohesiveness; external challenges and team work.

I then reverted to manual review. I reviewed the transcripts again following the eight-step approach proposed by Tesch (1990: page 142 - 145) within the three groups and then across all transcripts. First, rereading all the transcriptions and noting points that stood out. I then reread the transcriptions for the underlying meaning that emerged in each. During this process, I made a list of the categories that emerged in each transcript. I grouped any that were similar. I gave each category a code. I went through all the transcripts again, highlighting segments of text and annotating these with the codes. The categories and their identifying codes are shown in Table 1, below.

Table 1: Categories and Identifying Codes

Categories	Codes
Training	T
Content	C
Problem solving	PS
Leadership	L
Quality	Q
Applying training	A
Leadership part stopped – pulled out	PO
Team work	TW

Impact of leadership on quality	I
Cascade learning	CL
People moved	P
Integration	INT
Process	Pr
Empowerment	E
Resistance	R
Methods	M
Collaborative approach	C
Benefits of the programme	B
Ownership	O
Use of data	D
Organisational issues	S
Change / behaviour change	BC
Culture	CUL

The two extracts below, from an interview questionnaire, illustrate how highlighting and codes were used to show the categories in the responses of the participants. The first identified cascading learning and the second how the two programmes were integrated. (See Appendix 7 for an example of a full transcript).

CL “we showed them the whole process of identifying a problem, and trained them to solve the problem using the LDP format – we were cascading the whole thing to the lower levels so they were able to make progress”.

“So to use the tools to help the service element scores. So if a service element had non-compliant something so we were using the knowledge and skills of the LDP –to bring those to partially compliant or compliant.” **INT**

I reread the transcripts after coding all the categories and there were common themes emerging. I then used a mind map to group the twenty-three categories that I had identified from this process. This entailed identifying common words in the category and rereading the context in which the interviewee referred to the category. This enabled me to group the categories and identify six themes.

The diagram in Figure 6 shows which categories were grouped in the mind map to give the final themes that were used for the analysis.

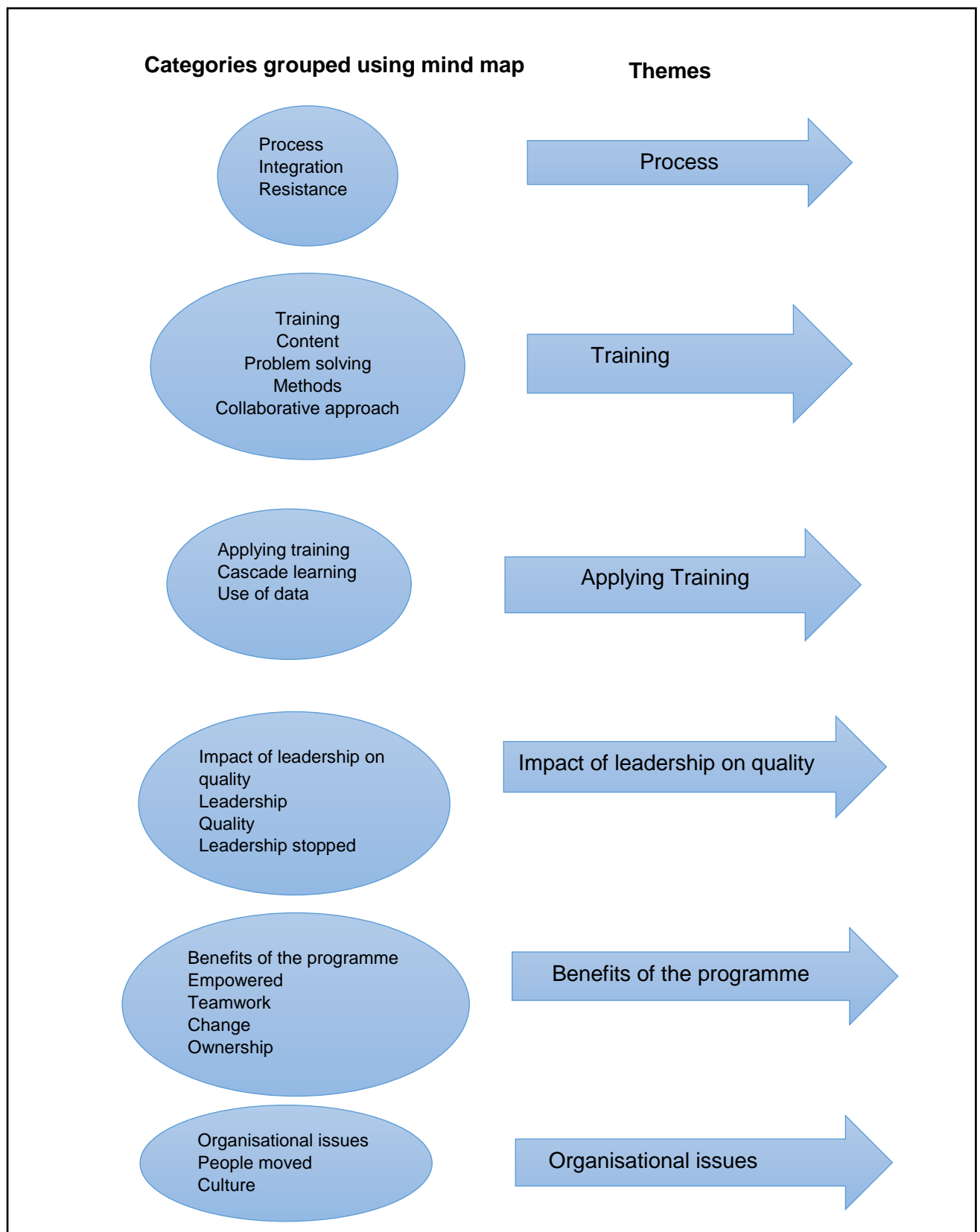


Figure 6: Illustrating how a mind map was used to group *categories* and identify the *Themes*

The logic that I applied using the mind map (see Figure 6) to arrive at the six themes was as follows:

Training: This theme included, training and the content of the training as well as problem solving and collaborative approaches, as when the interviewees talked about these, it was in the context of identified training needs or training that was done and how this was carried out.

Applying training: Participants were asked specifically how they had been able to apply the training they were given. A number also referred to 'cascading learning' through the organisation and emphasis was put on how they had learned to analyse and use the data to address problems or deficiencies.:

Process: This theme arose predominantly from the MSH and COHSASA respondents in relation to what the two companies did to bring together the programmes, their views on how the programmes were or were not integrated and the resistance from some parties within their organisations to the idea of combining the programmes.

Impact of leadership on quality: The hospital and MOH respondents were asked how they thought the leadership input affected the quality improvement activity, all were able to describe this and also referred to when the leadership 'stopped'. MSH no longer being onsite was also referred to by the COHSASA and MSH respondents.

Benefits of the programme: This theme emerged clearly from the various categories. All respondents were asked to talk about the benefits of the programme. The hospital and MOH respondents particularly talked enthusiastically about feeling empowered, having a sense of ownership and noticing a change in the way people worked. Improved teamwork was cited as a specific benefit.

Organisational issues: The interviewees talked about staff being moved and different parts of the organisation being responsible for different parts of the programme. Most of these issues were outside of the control of the participants but did have an impact on the programme, hence the theme organisational issues emerged.

The secondary statistical evaluation data, which was collected by the organisations, was reviewed to see the progress that was made by the facility staff towards achieving compliance with the accreditation standards, an indication of improving quality. The

process of data collection is that COHSASA carried out a Baseline Survey, during which all criteria, which make up the standards, were assessed in all the hospital departments. The compliance level of each criterion, that is non-compliant, partially compliant or fully compliant, was captured into CoQIS. Based on programmed business rules, the system allocates a score for each criterion. These scores were aggregated to give a score for each standard, which in turn were aggregated to give a department score. The compliance scores of all departments were aggregated to give an overall score for the whole hospital. After the Baseline Survey, the hospital staff carried out self-evaluation of the criteria in their departments and captured any changes, together with comments as to why the change was made, into CoQIS. These were carried out at eight-weekly intervals. After a number of these self-evaluations, the COHSASA and QIL team carried out a sampled validation to validate the accuracy of the self-evaluations. During these visits, they could not review all the criteria but were able to indicate if the scoring on the sampled criteria was overall accurate. At the end of three years a Progress Survey was carried out, during which all the criteria across the hospital were evaluated. The evaluation times selected for review were those when the COHSASA and QIL team carried out the evaluation to give an objective assessment. The evaluation findings are set out in the next chapter.

Summary and Conclusion

The thematic analysis revealed a number of key conceptual categories that were evident in the interview data collected across all the participants. The thematic analysis of the data identified twenty-three categories. These categories were distilled into six themes: process; training; applying training; impact of leadership on quality; benefits of the programme and organisational issues, by re-listening to the tone and emphasis placed on words or topics during the interviews, repeated reading of the transcripts to identify common factors that emerged or interesting and different observations or comments from the respondents. These were then grouped using mind maps, which brought together the six themes. In addition, the secondary statistical evaluation of standards compliance data was extracted from CoQIS and reviewed. The themes and data were then reviewed with regard to the two research questions. The findings of the analysis are set out in Chapter 5.

Chapter 5: Findings

Introduction

The findings are derived from the results of the semi-structured interviews. The interview questionnaires are at Appendix 5 and 6. During the interviews and the transcription process, it was evident that all the respondents had framed their responses predominantly within the interview questions and I therefore organised the analysis around the main questions. I then used thematic analysis, and from this have drawn out the analysis to indicate the prevalence of a number of key conceptual themes that were evident in the interview data collected across the participants. This will be demonstrated through reference to quotes from the semi-structured interviews.

Discussion of demographic information

The study sample of participants was drawn from the stakeholder organisations of COHSASA, MSH, the Ministry of Health and one selected hospital. This provided a cross section of views about the introduction and impact of the programme. The demographic details are shown in Table 2.

Table 2: Demographic details of Participants

Pseudonym	Age band	Gender	Qualification	Role
Jon	41 – 50	M	MSc Geography MSc Geographic Information Systems	MSH Manager
Mary	51 – 60	F	RGN RM Diploma Primary Health Care	COHSASA Facilitator
Lunga	41 – 50	M	MBChB MBL FCOG	COHSASA Facilitator
Dikeledi	51 – 60	F	BPharm MPharm	MOH Officer
Mpho	41 – 50	F	BNursing	MOH Officer
Thapelo	41 – 50	M	MD MPH	MOH Officer
Kopano	60+	M	MB, ChB. MRCPsych	Hospital doctor
Kefilwe	31 – 40	F	BScOT	Hospital Allied Health Professional (AHP)
Kagiso	51 – 60	F	RGN; BSc Nursing Ed MSc Comm Health	Hospital Senior Nurse

Thematic Analysis

Through repeated reading and coding of the transcripts, twenty-three categories were identified. Further reading and mind mapping grouped the categories into six key themes. These were: process; training; applying training; impact of leadership on quality; benefits of the programme and organisational issues. Each of the themes has

been dealt with in turn, supported with reference to quotes from the semi-structured interviews in order to demonstrate how they emerged from the data.

Theme 1 - Process

The theme of process was predominantly from the MSH and COHSASA respondents in relation to what the two companies did to bring together the programmes, their views on how the programmes were or were not integrated and the resistance from some parties within their organisations to the process. At the start, there were discussions with people working on the ground, suggesting bringing the programmes together would be beneficial.

“I think myself, X and Y were toying with the idea of putting them together as it made sense. We discussed with Y trying to pilot in Botswana”. (Lunga, COHSASA facilitator).

These ideas then had to be put to the two organisations to get endorsement.

“It involved a lot of convincing because both organisations had fully fledged programmes they were very proud of” ... There was that initial resistance on the part of COHSASA”. (Jon, MSH Manager).

Once the process began it seemed it was systematic.

“In terms of the nuts and bolts of the integration, what we did was to take a closer look at the COHSASA programme and the timelines and for instance, all of those areas of the programme that included things like validation, revalidation or external evaluation, we kept all of those statuses of the programme. So in each of the phases of the COHSASA programme we incorporated the relevant managing and leadership practices and we put all those things together”. (Jon, MSH Manager).

Another respondent commented on the process that,

“After lots of negotiations we worked with our standards and their methodology and then we worked as a team”. (Mary, COHSASA Facilitator)

The word ‘team’ gave an indication that the process was integrated. However, there was some contradiction to this,

“We just had a slot of time to talk about COHSASA”. (Mary, COHSASA Facilitator).

The respondent then went on to say,

“We were totally involved and so in the workshop we involved in what people did – watching to see if it was the right thing so we were facilitating with them right through. So with our standards and their methodology... we integrated the two”. (Mary, COHSASA Facilitator)

This implied that there was integration, at least during the training at the start of the programme.

Another respondent supported this with a view of the complementary nature of the programmes that enabled integration,

“It used to gel so well. It went very well. There were some ‘Aha’ moments from some of the leadership within the government sector where they saw how it worked together”. (Lunga, COHSASA Facilitator).

The combining of a skills-based and a standards-based approach appear to have been seen as effective by some parties, one participant observed,

“I think it really worked because suddenly we began delivering the same message. We were on the same page and agreements reached in those rooms were consultative and even now for us all to buy into it ... we stopped calling ourselves from MSH or COHSASA rather we were calling ourselves the QIL team, all with a view to breaking any ... inter-organisational barriers that the participants could or would perceive”. (Jon, MSH Manager).

The respondent also observed that there was an impact on the client group,

“The participants stopped calling them COHSASA or MSH they called them the QIL people or the QIL team and for me ... who knows where we are coming from – to get participants refer to us like that was a major, major achievement because it goes to, went to show that they really got it, that we were no longer presenting ourselves as different groups but rather one group”.

However, within the client group, there was only one similar reference which stated,

“You remember when we first started there was COHSASA and it was called the COHSASA project but after, when we had trained they came back and the language had changed. They were calling it accreditation and quality improvement in our health facility”. (Mpho, MOH Officer).

Although there was a move away from the 'COHSASA' programme, this statement seemed to imply the identification of the programme within the health facility rather than the QIL process itself, that is the combined quality improvement, accreditation and leadership development programme, being integrated across the health system. One of the hospital respondents noted that,

“Briefly they introduced them together and said it was one thing but then they covered the different categories and at the end they were separate, but they were introduced together”. (Kefilwe, Hospital AHP).

This suggested that the 'trainees' were able to discern that at the outset the programme comprised two separate entities.

Theme 2 - Training

Participants from MSH and COHSASA were asked how they were able to combine the training methods and content of the two programmes. One respondent noted that,

“COHSASA and MSH spent some time meeting virtually to plan the training so we agreed on the content, who was going to deliver what, we even agreed how it would be delivered. Because of that it made it very easy for us to be collaborative in the delivery of the training”. (Jon, MSH Manager).

This indicates that at the early stage of the programme, there were detailed discussions and consensus among the teams in the two organisations about the training. Another respondent supported this view and was positive that the two organisations brought different dimensions to the training, which were complementary.

“Well there was a combining of the training. There were some areas of overlaps but in my opinion it was combining very well. It didn't look separate at all. The MSH training is skills training and it can be applied in any set up. So we then provided a platform - in the health system. COHSASA standards – this is how we assess and identify the problems and then MSH would say if we apply the leadership skills methods”. (Lunga, COHSASA Facilitator).

Another respondent also made reference to two components, being the COHSASA standards and the MSH methods.

“To train the staff using our standards and their methodology and solving a problem. The objective of both MSH and quality ... COHSASA was to reach

compliance and solve the problem and maintain compliance throughout”.
(Mary, COHSASA Facilitator)

This indicated that there was a common objective that was being addressed in the training, which was supported by this statement;

“COHSASA standards – this is how we assess and identify the problems and then MSH would say if we apply the leadership skills methods – it gives the skills for how you might go about it”. (Lunga, COHSASA Facilitator).

The respondents distinguished between the COHSASA standards, being the ‘what’ and the MSH methodologies, being the ‘how’. Although the following statement implied that both organisations trained on methodologies and that perhaps there was not complete agreement on the approaches,

“Theirs was a long, long winded approach whereas ours was to the point, you solve the problem, you monitor and achieve, then you monitor over a period of time”. (Mary, COHSASA Facilitator).

During the interviews, the participants from the Ministry of Health and the hospital were asked to describe the training that they underwent. The respondents referred to the different components of the training.

“In that training ... we took our leadership concepts and we applied them to the non-conformities that were brought up and we had issues to be addressed and we applied the leadership concepts that were being taught ... We were taught things like scanning, like focusing, like planning, like organising, like, yes monitoring and evaluation”. (Dikeledi, MOH Officer)

This reflects the joint approach described by the COHSASA and MSH respondents, with the participants being trained to use the various improvement methods, taught by MSH to address the problems that caused the non-compliance with the COHSASA standards.

Some referred to the specific organisation and some to the actual content of the training:

“They trained us on accreditation, issues of standards, criterion, then MSH talked to us on leadership and management, how do you motivate other officers, issues of customer care, how to develop plans”. (Thapelo, MOH Officer)

This indicates that the training, whilst delivered jointly was discerned by some of the participants as being delivered by separate organisations. This is factual and perhaps to be expected at such an early stage in a programme.

However, another respondent stated that,

“I think they were just introducing COHSASA as an organisation and the service elements we are dealing with” ... “The leadership development programme – I did not do that. We did the fishbone, how to identify problems and later how to solve them, using the fishbone”. (Kagiso, Hospital Senior Nurse).

The respondent is suggesting that she only attended the ‘COHSASA training’ but then went on to describe one of the methodologies taught as part of the LDP, which suggests that the training was integrated, and that the participant could not discern that she was having training provided by two different organisations.

Some respondents also identified different workshops they attended and a range of content. Two referred specifically to training on the accreditation process:

“(I was in the) Group that was trained to be able to do like quick auditing, they trained us in the accreditation process”. (Mpho, MOH Officer).

“I attended a QIL and accreditation training followed by CoQIS” (using the information system). (Kopano, Hospital Doctor).

These are important observations as the goal of the joint programme was to see if it was possible for the facilities to achieve accreditation more quickly and it was therefore critical for those both at Ministry and hospital level to understand the process. The training on the information system was to ensure the staff could use the data that had been captured on the standards compliance, to develop quality improvement plans and monitor their progress.

One respondent was able to contextualise the training,

“It was about management and dealing with issues at work and managing the work every day in the department, just the management of everything and what to expect from leaders”. (Kefilwe, Hospital AHP).

This is an important observation as it indicates that the respondent had grasped the concept that quality improvement is part of everyday work and that the leading and managing practices would help to achieve this.

An interesting observation was made by one hospital respondent in terms whether COHSASA and MSH managed to combine the training effectively was,

“Briefly they introduced them together and said it was one thing but then they covered the different categories and at the end they were separate. I did the quality after, they were done differently but at the end of the day I realised they were together, you cannot separate them”. (Kefilwe, Hospital AHP).

This indicates an understanding of the concept of the standards being the ‘what’ and the various improvement methods together with the leading and managing practices being the ‘how’

This supports the view expressed by one of the COHSASA / MSH respondents,

“It didn’t look separate at all. So we then provided a platform - in the health system. COHSASA standards – this is how we assess and identify the problems and then MSH would say if we apply the leadership skills methods – it gives the skills for how you might go about it”, (Lunga, COHSASA Facilitator).

This summarises the intent of the training, which was to ensure that the participants understood the standards and could use the various improvement methods and leading and managing practices to address deficiencies. Together, they gave the staff the necessary knowledge and skills ultimately to prepare their hospital for accreditation.

Theme 3 - Application of Training

MOH and hospital participants were asked how they had been able to apply the training to quality improvement activities and to share the training with others involved in the process. (Questions nine and ten in the semi-structured interviews – see Appendix 5). There were positive responses with the interviewees giving practical examples of the application and sharing of training.

“Other people they went to be trained at how to train other people, and then other people, we’ve assisted in the implementation of the quality improvement part”. “We were imparting to them what we had learned”. (Dikeledi, MOH Officer)

This respondent like other MOH respondents was very clear that the learning had been shared widely.

Another respondent described the process;

“We formed teams in all the facilities and we showed them the whole process of identifying a problem, and trained them to solve the problem using the LDP format – we were cascading the whole thing to the lower levels. We had everything, we had training manuals – so everything we had been taught were able to give to them. To share the information”. (Mpho, MOH Officer)

It is interesting that the respondent referred to ‘LDP format’, which could indicate a lack of integration, although it is being used to solve problems, these being non-conformities with the standards and the overall opinion was positive.

The hospital respondents described being able to use the training to implement the programme. One respondent indicated that the programme was integrated by referring to the QA/LDP training and went on to describe the practical application of the training.

“I was able to set up a QIL team at ‘North Hospital’ and ‘South Hospital’

“I trained the hospital staff members ... on quality improvement activities and we used the skills from the QA/LDP training to cascade learning from the departmental management level to unit level, down to ward level ending with the individual staff”. (Kopano, Hospital Doctor).

One respondent recounted a comment from a colleague, who said,

“But it was you who trained me – to do everything, I didn’t go to any training”.

From this the respondent was able to reflect,

“So I was able to transfer the knowledge to another person who took over after I left”. (Kefilwe, Hospital AHP).

This comment indicates not only the sharing of learning but also a degree of sustainability by training someone else before leaving the department or hospital. This confirms that participants were able to apply the learning they gained and that there was a genuine sharing of learning.

All the MOH respondents also indicated that they were using the learning in their own work environment in the MOH, not just applying it to the QIL programme in the hospitals.

“We were implementing it here at the directorate”. “Even now I am still using the learning from the project, especially when I am faced with a situation”. “I

loved the programme so much and it gave us lots of tools to use". (Mpho, MOH Officer).

The hospital respondents also indicated the usefulness and continued use of the methodologies;

"Scanning the environment and mobilizing resources with help of stakeholders was the most helpful". (Kopano, Hospital Doctor).

The doctor identified certain of the leading and managing practices that he had been able to use and that had helped to improve the quality of service in the department.

Another gave details of the methods staff are continuing to use;

"Yes some are still using leadership training. Some have some projects they are still working on. They are using the fishbone model. They are using the cause and effect analysis". (Kagiso, Hospital Senior Nurse).

This was in contrast to the statements of a respondent in the MSH / COHSASA group which stated that,

"In the hospitals people did not use the methodologies afterwards – they had the training, they had handouts but in the hospitals the people don't use any of the methodologies". (Mary, COHSASA Facilitator).

This response could indicate that the respondent does not use the methodologies or perhaps does not look for their use by the staff in the hospitals.

The respondent then continued,

"They don't understand the fishbone but the why, why, why they still use. But they look at the system, what is the problem, monitor, is there improvement? Most of them use the plan, do, study, act approach which is easy for them". (Mary, COHSASA Facilitator).

The respondent contradicts the previous statement that 'they don't use any of the methodologies'. It also directly contradicts the hospital senior nurse who stated that the fishbone method is still being used by staff for quality improvements.

Part of the training for the MOH and hospital staff was on understanding and being able to use the COHSASA standards to improve the quality of services. They were trained how to carry out self-assessments in their hospitals and record the standard compliance data on paper and capture it into the CoQIS information system. There was specific training for designated individuals on how to use the CoQIS information

system to monitor and manage the standard compliance data in order to use it to develop quality improvement plans. The compliance with the standards was reassessed in the hospitals every eight weeks.

This respondent reflected positively that she was able to apply the training by using the data to assist the hospital staff;

“We were trained on the ground with the information from COHSASA and then we were able to interrogate the data with the facilities and help them to understand the results and then we were able to help them with the next step and then from there now we were using the MSH programme to help them to deal with their problems as identified in the assessment”. (Mpho, MOH Officer)

This is positive as the role of the MOH staff was to support the staff in the facilities to implement the programme so they were trained to use the standards compliance data, the improvement methods and the managing and leading practices in order for them to do this.

Another respondent stated;

“It was now clear what is the accreditation process, what is it all about. What are the requirements, how do we go about to meet the requirements? I think I came to learn why and how to implement the accreditation programme. And issues of leadership we were now advancing our ability”. (Thapelo, MOH Officer)

Both these statements indicated that the staff on the ground had linked the training inputs and were able to apply the leading and managing practices and methods to move the hospitals towards compliance with the standards. This speaks to the intent of the training provided by MSH, which was to enable recipients to continue to use the learning after the training;

“Because that is the essence of the leading and managing part that people are able to be proactive and take on challenges without waiting for external assistance”. (Jon, MSH Manager)

MSH used questionnaires to establish baseline data on staff perception of the application of leading and managing practices within the hospital. (Question 11 on the semi structured interview questionnaires) - (See Appendix 5). This was a 360-degree assessment. The questionnaires were applied to establish the perception of the individual of his or herself, the perception by peers and subordinates of the application

of the leading and managing practices within their department and the perception of the supervisor. There was limited sharing of data collected on these questionnaires between COHSASA and MSH;

“I would see the data they collected before and after but when it went beyond then I didn’t. the finer detail that was beyond me”. “This was the same as with the COHSASA data, we shared the overall but the finer details of this would escape them”. (Lunga, COHSASA Facilitator).

This identifies a weakness in the programme, that COHSASA and MSH did not actively link up the various tools for monitoring the effect of the training, which could have perhaps more accurately assessed the success, or not, of the programme.

Another respondent stated;

“They explained it but we didn’t see the analysed data. No, no link up. We only saw what was in CoQIS, the COHSASA data”. (Mary, COHSASA Facilitator).

This was perhaps a factor of time, that this data was not shared or perhaps that the staff of the two organisations only felt ownership of their own data.

Only two of the MOH and hospital respondents were able to comment on completing the questionnaires. One stated;

“I can remember before we started we did it and then immediately after the training but not after that”. (Kefilwe, Hospital AHP).

This response implies that the questionnaire was completed but does not indicate if that there was feedback on the results.

The other commented;

“Yes I did it once - at the start and then I did it after the training and gave it to the MSH Facilitator. Then we applied it to all of them before the training. When we did it the second time we could see there was changes”. (Mpho, MOH Officer).

It would seem that questionnaires were completed by participants of the various training workshops and were reviewed locally. (I did not have access to these documents). It is not clear how much feedback was given to the participants. The purpose of applying the questionnaires was stated as:

“For us it was to provide evidence for of the leading and managing practices that the participants claimed could be demonstrated. So by having the data we

were able to triangulate the data with a supervisor and a colleague". (Jon, MSH Manager)

An overall review of the evidence, impact on individuals or the programme could not be completed as a suitable database was not available and because of time constraints. This is confirmed by an MSH Manager,

"The leading and managing practices questionnaires were analysed to some degree, it was very promising but we did not go very far – simply we basically ran out of time. There was no time for us to go back and do a follow up assessment and be able to compare". (Jon, MSH Manager)

All the standard compliance data, collected from the Baseline Survey, at every self-assessment carried out by hospital staff at eight-weekly intervals and at all assessments carried out by COHSASA staff, was captured into CoQIS. The collated data could be made available on-line or in hard copy. The data underpinned the planning for quality improvement activities and confirmed where progress was being made. Whilst it was used in the initial training, it seems that, as with the data from the Managing and Leading questionnaires, it was not shared in detail between the COHSASA and MSH teams.

Overall the hospital and MOH respondents demonstrated that there was active application of the training and widespread sharing of learning. All the interviewees also confirmed that they have continued to use the improvement methodologies and the leading and managing practices, both at work and in their personal lives. The sharing of data between COHSASA and MSH could have been done more effectively. The time constraints proved a challenge to making direct relationships between the data collected on the leading and managing practices and the rate of improvement with the COHSASA standards.

Theme 4 - Impact of Leadership on Quality

The MOH and hospital interviewees were asked how the leadership (LDP) input affected the quality improvement activity (Question 13 on the semi- structured interview questionnaire – see Appendix 5). In addition to the responses to the specific question, interviewees made reference to this in responses to other questions, hence it emerged as a strong theme.

The hospital and MOH respondents indicated that there were benefits to using the managing and leadership practices to implement the quality improvement activities;

“We called it the quality improvement and leadership programme, the QIL programme. When we realised that the quality improvement programme was going better with the LDP”. (Dikeledi, MOH Officer).

This is a positive statement both in terms of the perceived impact of the LDP on the quality improvement and accreditation programme and an indication of ownership of the programme.

They were all able to give practical examples;

“Now we were able to understand more the quality and leadership and how leadership applies to quality and how to meet or rather close the gaps and what methodology to use”.

This is a positive statement that indicates an understanding and practical application of the leadership skills to quality, also that the respondent was able to select different improvement methodologies. The respondent went on to say;

“I could compare the facility that was in for accreditation and the facility that is not in for accreditation so I think the leadership input had an impact on those facilities undergoing accreditation”. (Thapelo, MOH Officer)

Within this theme the MOH and some COHSASA / MSH respondents made reference to the ending of the leadership component and MSH ‘pulling out’, as a factor that affected the progress of the overall programme. One respondent said;

“You see that’s where we were working nicely together but then we just used the COHSASA standards. You see then there was nobody to talk to them about the QIL They stopped and then people lost interest”. (Mary, COHSASA Facilitator)

This response implies that combining of the programme was not as robust as intended. Although the training of all the MOH and hospital staff had been done jointly and the programme was called the QIL programme, the COHSASA team did not continue to make reference to the various methodologies and leading and managing practices.

Another respondent commented;

“There was a lot of difference when the leadership programme was there and when it wasn’t there. I think things were moving faster. When the leadership programme was being implemented at the same time as the quality programme”. (Dikeledi, MOH Officer).

This also seems to suggest that those in the MOH were seeing two separate programmes; she refers to the 'leadership programme' and the 'quality programme', not the intended, integrated QIL programme. Another commented that:

"Definitely the programme took longer because the leadership component didn't go through - as it moved on the leadership part of it kind of died away".
(Mpho, MOH Officer)

It is clear that the MOH staff believed the joint programme to be more effective and it is not clear why 'the leadership part died away' as many staff had been trained and confirmed they continued to use the skills.

One respondent expanded on this:

"My observation is that the leadership aspects are very critical and maybe before anything is done the issue of leadership has to be okay, because leadership is not just about senior management it is at all levels, in all departments, the issue of leadership is critical. While there is that misunderstanding of leadership we will not solve quality".

The respondent gives a very strong view about the impact of leadership on quality and the importance of leadership being at all levels of the organisation. The respondent went on to say,

"Because what is happening now is if people are speaking about COHSASA – it's not about leadership so that's what went wrong with the QIL programme".
(Thapelo, MOH Officer)

This reflects the statement by the COHSASA respondent earlier "then we just used the COHSASA standards". However, this is not reflected in the interviews with the hospital staff who indicated that the methodologies and skills continued to be used and also commented on the positive aspects of the programme:

"The LDP positively affected the QIL activities. I was able to scan the environment, networked and applied the techniques learned". (Kopano, Hospital Doctor)

The respondent clearly articulates the positive effect of the LDP on the programme and specifies the practices he particularly used.

Another respondent added;

“It does because there is no way you can do quality without the input of the leadership ... there’s no way you can separate leadership and the juniors and the quality part of the hospital – of the organisation”. (Kefilwe, Hospital AHP).

The training had been given and was being applied and from the responses from the hospital interviewees there was a positive impact on the quality improvement activities.

“And you can see the quality of care is improving. Yes, yes some are still using leadership training. Some have some projects they are still working on”. (Kagiso, Hospital Senior Nurse).

It was a fact that because of the funding cycle, the MSH staff had to complete their inputs by a given date. As stated by one of the MOH officers:

“The fact was that, MSH had to stop because of the money, the funding stopped”. (Dikeledi, MOH Officer).

From a COHSASA / MSH respondent the following observation was made:

“And besides that we were going to test whether the approach in itself, you know the training for participants to take on leading and managing responsibilities that they would be better able to take on and sustain the accreditation”. (Jon, MSH Manager).

It was of concern that although there was positive impact seen in the hospital, there was not enough time to carry out detailed assessment of the longer-term benefits.

“I was hoping that we would be able to answer the question that did the QIL programme bring accreditation faster. I still go back to the painful issue of not having the time we needed to see the programme through”. (Jon, MSH Manager).

These comments indicate that the respondents were seeing the benefit of the leadership component being used together with the standards and quality improvement activities. This partly answers the second research question:

‘As a result of the integration of the two programmes, has there been any greater improvement in compliance with the COHSASA healthcare facility standards than would be expected when the COHSASA programme is delivered independently?’

The secondary statistical data was reviewed and the findings are discussed below.

Theme 5 - Benefits of the programme

During the interviews, all the participants were asked to describe the benefits of the programme (question 17 in the MOH / Hospital questionnaire and question 8 in the MSH / COHSASA questionnaire) (Appendix 5 and 6). All interviewees in all groups indicated there had been benefits and this emerged as a theme as a number of benefits were identified when answers were given to other interview questions. The question to the MSH and COHSASA interviewees was whether in their view the combined programme was more beneficial than their original programme. In addition to the responses to the specific question, interviewees made reference to this in responses to other questions, hence it emerged as a strong theme. One respondent described the process,

“What were we doing for quality improvement through COHSASA, we did the surveys to identify what were the issues that facilities were having in terms of health care management systems - what are short falls. This is what you need to do to fix it. Then tried to facilitate at every level – clinical, management and all the services - this is what you need to do to fill the gaps – it was sort of working. The LDP answered the HOW part”. (Lunga, COHSASA Facilitator).

This theme speaks directly to the first research question: “Was there any benefit in the integration of the MSH Leadership Development Programme with the COHSASA Quality Improvement and Accreditation programme?”

Some of the benefits identified, included staff being empowered, being able to make changes in their own environment and feeling some ownership of the programme. These observations came from the COHSASA / MSH respondents,

“After the training people felt empowered and were able to take charge and manage whatever problems they had”. “It was empowering - makes them understand they are skilled enough to contribute to changing the environment around them”. “So they could see the benefit of the two was much better than just the one programme alone”. (Lunga, COHSASA Facilitator).

The statement is strong in confirming that the participants could see the benefit of the joint programme and also that they were able to ‘take charge and manage problems’. Empowerment was also a positive response from a hospital interviewee,

“Thank you to you guys for the knowledge you imparted. You empowered me”.
“Once people are empowered with the proper knowledge they will be able to even change themselves”. (Kefilwe, Hospital AHP).

The MOH respondents identified improved teamwork and identifiably different behaviour within the participating facilities, including improved initiative and innovation.

“So we inculcated the team spirit with the hospital – the facility people – so that as they moved they could all see themselves as contributing to the issue. So people should work as a team”. (Mpho, MOH Officer).

This suggests that the training and support had a positive effect and also indicates empowerment and motivation as the staff saw themselves making a contribution.

“The leadership development programme was working with teams in the facilities – problem solving teams working on issues on accreditation issues”. (Dikeledi, MOH Officer).

This response indicates that at ground level there was integration as the teams were using the LDP methods to address the requirements of the accreditation standards.

An MSH / COHSASA respondent included the benefit of the teamwork between the COHSASA and MSH staff, within the programme.

“The value of being there as a team as the QIL team, COHSASA and MSH on the ground in the facilities working as a team. I think that was quite invaluable but difficult to quantify financially”. (Jon, MSH Manager)

Besides improved teamwork, MOH respondents also identified changes in behaviour of hospital staff, including improved initiative and innovation.

“The facilities that are under the process, the people are different you see different behaviour, the people they are like - the people are working together to do the right things.” (Mpho, MOH Officer)

The officer notes the behaviour changes which led to the staff doing the right things – one of the adages of quality improvement is to do things right first time.

“The initiative of the people who were actually leading those areas because the areas where people were willing, changes were happening, where people would innovate and discuss and make the changes move on very well.” (Thapelo, MOH Officer).

This is a positive statement from which the MOH officers were able to see the changes in activity and behaviour as a result of the programme.

These views were supported by the benefits of the programme identified by the hospital respondents in answer to question number eight on the hospital / MOH questionnaire,

“The hospital staff have now embraced the QIL concept despite the initial resistance to the change it brought about. They now own the process” ... “The department should meet the threshold for accreditation. This has been achieved by inspiring staff, initiating change and demonstrating the benefits of improved structures and QIL. (Kopano, Hospital Doctor)

In this comment the respondent refers directly to some of the categories that were grouped under the theme of benefits of the programme: change and ownership. There is also reference to using the leading practice of inspiring.

“We were able to turn the hospital around” ... “In most cases we worried about the stats and the numbers, not the quality part of what you were doing. So for me, I learned a lot about the quality part of the programme”. (Kefilwe, Hospital AHP).

This respondent identifies her personal learning and how this contributed to the overall improvement at the hospital.

“The hospital is using it - quality of care has improved”. (Kagiso, Hospital Senior Nurse)

The senior nurse's response refers to benefit of the programme having a direct impact on the quality of care.

“This helped in making sure that the knowledge on issues of quality improved. Leadership improved, again the interaction between myself and the facilities improved”. (Thapelo, MOH Officer).

A respondent from the MOH reflected on both the improvement in knowledge and relationships that occurred.

There were also reflections of benefits of personal growth and development,

“It developed me into a better person how I deal with things in my own career, even to think about taking a position in management. It was very beneficial for me”. (Lunga, COHSASA Facilitator)

This speaks to empowerment, to enable a person to want to move up in their career.

“In me I could see very much change in self – after the programme I could see that whatever you do, you do can change it”. (Mpho, MOH Officer).

Again, empowerment comes through strongly in the personal growth.

The benefits of the joint programme were clearly identified by all the respondents. All used words such as empowerment, team spirit, improved behaviour, ownership, and spoke of personal growth and improved relationships. With so many positive statements, it is difficult to identify why the momentum of the programme was not sustained.

Theme 6 - Organisational issues

Although organisational issues were not included in any of the semi structured interview questions, this emerged as a theme, which came from categories about culture and staffing. First there were issues relating to COHSASA and MSH working together to combine their two programmes; the relationship between the two organisations and the MOH and the hospital. Organisational issues also emerged within the MOH and between the MOH and hospitals.

MSH is a large, US based NGO with global reach, whereas COHSASA is a much smaller organisation with an African footprint. In reflecting on the programme one of the respondents commented,

“I think for one that with that experience we were able to prove that two organisations from different parts of the world that have their own grounded programmes can be considerate enough to shift ground and to allow for the integration of two programmes into one”. (Jon, MSH Manager).

This is a positive reflection and none of the respondents from COHSASA / MSH referred directly to any differences in culture between the two organisations, although this was implicit as the teams included staff from South Africa, Botswana, Nigeria, Zambia, United Kingdom and United States. The differences discussed, related to the type of programmes they offered, the LDP being a very flexible programme and the accreditation programme having specific standards and some fixed processes.

Within the MOH, respondents commented on the organisational arrangements that were put in place for the programme, with two different directorates involved in the two

aspects, one leading on the quality improvement and accreditation and one leading on the LDP component.

“Maybe the way we were running the programme, maybe it’s the way we are conducting ourselves, maybe when we are at a meeting and there is an argument, how do we go about things like that. I think it can be a problem again part of the problem it’s the way we organise ourselves”. (Thapelo, MOH Officer).

This indicates that perhaps at the beginning of the programme the organisational arrangements were not considered fully by COHSASA and MSH with the MOH.

“Also the people trained in LDP were in a different directorate that had a contribution to the whole process”. (Mpho, MOH Officer)

The comment indicates the need to consider the roles and responsibilities of different directorates in relation to implementing the programme.

All the MOH respondents commented on the need to work together, to change the way the programme was running.

“But here we have different leadership who were not here when it was done and they don’t know it. When we can introduce it to new management members probably we can go somewhere. Maybe we need to share with the new management” (Mpho, MOH Officer).

The respondent reflects that since the start of the programme, the leadership of the MOH has changed and there is a need to inform them of the programme including the skills and experience that were built up during the programme.

“I think the leadership development arm that MSH was doing was equally important. And I am feeling that people need to pull together and it’s to train people in these soft skills because they don’t come naturally to all of us”. (Dikeledi, MOH Officer)

The respondent acknowledges the importance of the leading and managing practices that MSH brought to the programme, which are no longer explicit in the programme and perhaps need to be refreshed.

“So the QIL programme the way it should be run, the issues of leadership should be addressed first of all, what are the benefits of good leadership at management level, at all levels”. (Thapelo, MOH Officer)

Again, an explicit statement about the importance of the leadership component and the view that the programme may need to be organised differently.

For organisations like COHSASA and MSH that work as partners and provide technical assistance to ministries of health, at different levels within the health system, there was a need to recognise that, whilst being part of the same health system, each hospital is unique and may respond differently to the programme inputs.

“Each facility is different, the challenges are different, their realities are different and the obstacles that have to be overcome and the time it takes really varied and it varied depending on their commitment and the commitment they get from their principals and all of those kind of things, put together”. (Jon, MSH Manager)

This comment could also apply to the different directorates within the MOH, given the previous responses from the MOH officers.

Within the organisational theme, one of the COHSASA / MSH respondents noted,

“The Quality Coordinator who is actually a lower level employee, may be like a professional nurse and now this person is supposed to be talking to their matron about how to improve things – and at the same time this the same matron who is supposed to do their assessment at the end of the year”.

Hierarchy did not emerge among the categories, but from the statement it is noted as an issue in how the organisation structures the programme. A hospital respondent commented,

“They needed the influence and the buy in of the management – In most cases there is knowhow, the leadership would stand somewhere at a different level”. (Kefilwe, Hospital AHP).

It would seem in some areas there was distance between the management and those actively involved in the programme.

Respondents commented on staff movement, which happened regularly through the programme and created a challenge for continuity because of the loss of organisational memory,

“Staff being transferred is a big challenge. Because some people are working on projects and they are transferred to other areas, then they leave and it leaves a vacuum”. (Kagiso, Hospital Senior Nurse).

The comment implies there was little handover and projects were left, which had implications for the overall programme.

“If people get transferred they are in and out of this facility, then new people came in and this whole thing was lost ... People were shifted around and new people came into the programme who were not trained ... It was difficult because they moved people around”. (Mpho, MOH Officer)

This was also identified as an issue by an MOH respondent and as well as being an organisational issue, perhaps can also be reflected in the benefits of the programme where reference was made to ownership. If new people were not trained it suggests there was a lack of ownership in some areas.

Secondary statistical Evaluation Data

The secondary statistical evaluation data, which was collected by the organisations, was reviewed to see the progress that was made by the facility staff towards achieving compliance with the accreditation standards, an indication of improving quality. The compliance scores of all departments were aggregated to give an overall score for the whole hospital. The evaluation times selected were those when the COHSASA and QIL team carried out the evaluation, to give an objective assessment.

The second research question asked:

‘As a result of the integration of the two programmes, has there been any improvement in compliance with the COHSASA internationally accredited healthcare facility standards?’

The secondary statistical data was reviewed and the findings are set out below. Figure 7 shows the overall aggregated scores for the whole hospital from the Baseline Survey (AB) to the Progress Survey including four sampled validations that were carried out at intervals during the programme. It indicates that the scores improved from the Baseline (AB) to the third sampled validation (SV-3) and thereafter there was some deterioration. The Baseline and Progress Survey (PS) are the only times when all the criteria in all departments are evaluated and thus indicate the most reliable information. During the early part of the programme up to the second or third sampled validation, little improvement in the scores is expected as the staff need to put in place quality improvement plans and demonstrate with documented and practical evidence that the

activities are being implemented, in this way to show that they are moving towards compliance with the standards.

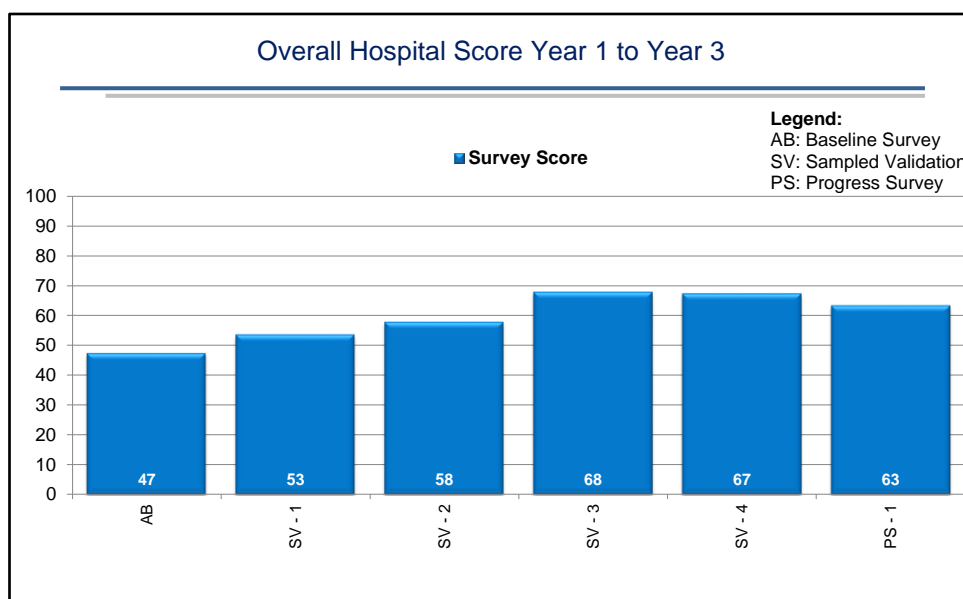


Figure 7 The overall standard compliance score for the hospital at each evaluation. The evaluation of the criteria within all the standards across the whole hospital was undertaken only at the Baseline and Progress Surveys.

Thereafter a gradual improvement of around ten in the overall scores could be expected at each sampled validation, if all other factors including available resources can be addressed. All departments must achieve a minimum score of 80, with no non-compliant critical criteria, which are incompatible with accreditation, for a hospital to be eligible for accreditation.

In Figure 8, the scores for the same time period for the Management and Leadership service element are shown. These indicate a similar pattern to the overall hospital scores but with a greater increase in the scores. However, at the Progress Survey, when all the criteria were assessed by COHSASA surveyors, the scores dropped even more.

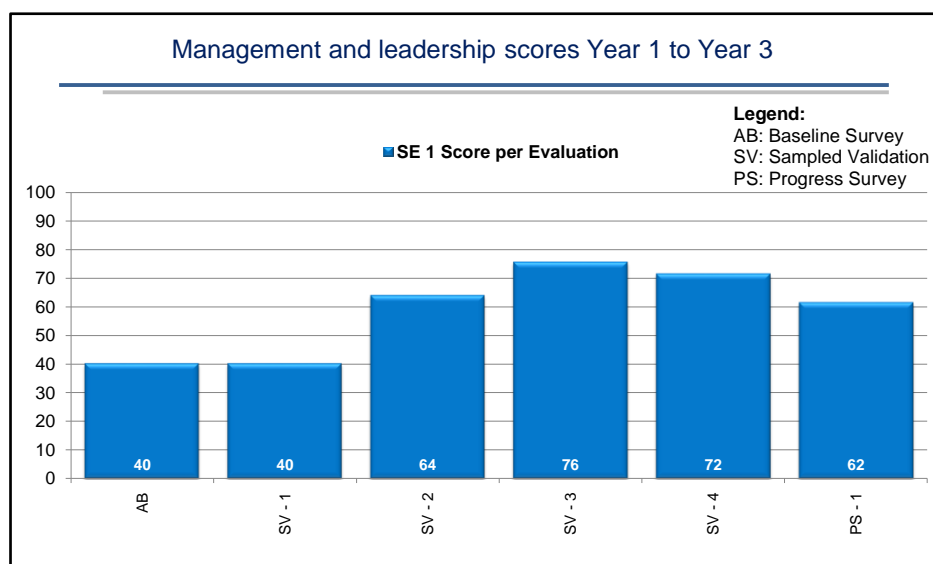


Figure 8 The overall standard compliance score for the Management and Leadership Service Element at each evaluation. The detailed evaluation of all the criteria within the standards was undertaken only at the Baseline and Progress Surveys.

The management and leadership score were analysed further to look at the three components called performance indicators, these being Governance of the Organisation (how the hospital board and organisation fulfils its governance requirements in relation to the Ministry of Health), Management of the Organisation (the overall strategic and operational management) and Management of Departments (the unit management and leadership function at departmental or service level). In Figure 9 it can be seen that while all the components made progress, only the management of the organisation achieved a score above 80. There were some departments that did achieve scores over 80 but not enough to raise the overall score to the required level.

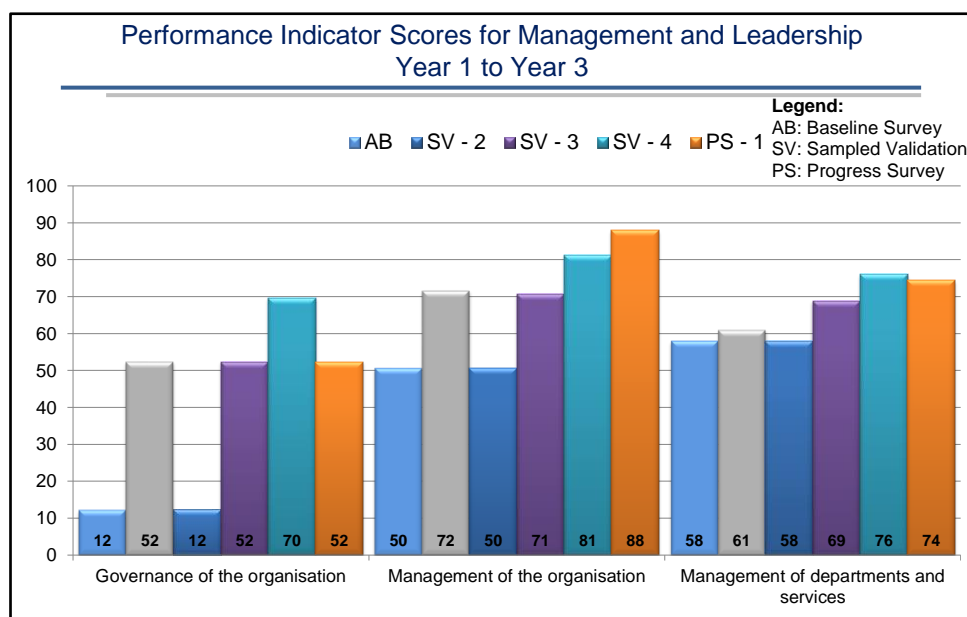


Figure 9 The compliance score for the three performance indicators within the Management and Leadership Service Element at each evaluation. The evaluation of the criteria within the standards was undertaken only at the Baseline and Progress Surveys.

Summary and Conclusion

The findings from the thematic analysis indicate that in all the six themes that emerged from the study, there was some consistency in information from the respondents. The process of integrating the programmes resulted in an agreed approach, which enabled training to be done on both the components of the LDP and the COHSASA standards and quality improvement. The MOH and hospital respondents were positive that they were able to apply the training. There were positive responses about the impact of the leadership on quality and the benefits of the programme. The organisational issues raised appear not to be directly related to the activities of MSH or COHSASA but need to be considered for their impact on the implementation. It is difficult to draw any inference from the standard compliance data as scores do not indicate better improvement than would be expected during a quality improvement programme using the COHSASA approach alone, but there are many other factors that are not part of this research study. The findings are discussed in Chapter 6.

Chapter 6: Discussion

Introduction

Prior to the development of the combined Quality Improvement and Leadership programme, MSH had introduced the LDP in a number of facilities in Botswana. When the COHSASA Quality Improvement and Accreditation programme started in the sites selected to pilot the joint programme, the LDP had already been introduced and the staff did not see the synergy between the programmes. Once the joint programme was developed, it was introduced in five hospitals. The hospital that is the focus of this study was one of those hospitals.

The six themes that have emerged in this study, process; training; applying training; impact of leadership on quality; benefits of the programme and organisational issues show that whilst there were different perceptions of the programme from the various stakeholders there were areas of commonality. All respondents identified some benefits of the two programmes being delivered together but there were some differing views as to the on-going programme.

Theme 1: Process

From the perspective of the process of how the programmes were integrated, initial resistance was identified within COHSASA but most of the respondents indicated this was overcome. However, one respondent indicated that perhaps some passive resistance remained, in that when MSH staff were not on the ground, there was little or no reference to the leading and managing practices. The funding of the joint programme was time limited, which meant that MSH staff were not able to work with COHSASA to test whether the combined programme enabled participants to achieve accreditation more quickly. One of the hospital respondents commented that,

“Briefly they introduced them together and said it was one thing but then they covered the different categories and at the end they were separate, but they were introduced together”. (Kefilwe, Hospital AHP)

This shows that the participants were able to discern that there were two parts to the programme but this was inevitable as the LDP is a skills based programme and the COHSASA programme is standards based but as observed by one of the COHSASA team,

“There were some ‘Aha’ moments from some of the leadership within the government sector where they saw how it worked together”. (Lunga, COHSASA Facilitator)

Ultimately, as one MSH respondent noted,

“I think it really worked because suddenly we began delivering the same message. We were on the same page”. (Jon, MSH Manager)

It was also noted both by respondents from COHSASA / MSH and the MOH, that the team was referred to as the QIL team no longer by their organisations’ names.

Theme 2: Training

The COHSASA and MSH respondents described how they worked to combine the training done by both organisations; one being a standards-based approach the other skills based,

“COHSASA standards – this is how we assess and identify the problems and then MSH would say if we apply the leadership skills methods”. (Lunga, COHSASA Facilitator)

This approach appears to have been successful as demonstrated by the comment from an MOH respondent,

“We took our leadership concepts and we applied them to the non-conformities”. (Mpho, MOH Officer)

There was a logical fit between the two approaches and all the respondents were able to describe the training and the application of the various improvement methods and leading and managing practices to the standards.

Theme 3: Application of training

How the participants were able to apply the training in the workplace and cascade the learning to others, for me is more important as it is an indicator of the training being shared and thus the programme being implemented. There was positive feedback from all the MOH and hospital participants. The first demonstrates clearly how the respondent was able to share and apply the learning across all levels of staff within the hospital.

“I trained the hospital staff members ... on quality improvement activities and we used the skills from the QA/LDP training to cascade learning from the

departmental management level to unit level, down to ward level ending with the individual staff". (Kopano, Hospital Doctor)

To assess compliance with the standards around 3,500 criteria were assessed across the hospital. This generated a huge amount of data and the staff needed to be able to understand and use the data to inform their quality improvement activities. The response from one of the MOH participants gives a positive description of how this was done,

"We were trained on the ground with the information from COHSASA and then we were able to interrogate the data with the facilities and help them to understand the results and then we were able to help them with the next step and then from there now we were using the MSH programme to help them to deal with their problems as identified in the assessment". (Mpho, MOH Officer)

The findings indicate that the training was applied and shared widely. A number of the respondents also reported that they used the skills they had learned in other areas of their work and personal lives. This indicates that local capacity and capability was developed, which enabled programmes to be sustained. It also meets the intent of MSH that, after the training local people should not be dependent on external assistance to address their challenges. Only one of the COHSASA respondents said that the methods were not used after the MSH staff left. This suggests that the skills and learning of the methods and leading and managing practices were used in the hospital but appear not to have been supported as part of the on-going programme by COHSASA staff.

Theme 4: Impact of Leadership on Quality

In the planning for integrating the COHSASA and MSH programmes one of the hypotheses was that combining the leading and managing practices and skills with the standards based approach would enable the facilities to achieve accreditation faster. Although the hospital did not achieve accreditation, the majority of the respondents indicated that the LDP input to the programme did have a positive impact on the quality improvement activities both on how it was implemented and the speed of implementation.

When we realised that the quality improvement programme was going better with the LDP". (Dikeledi, MOH Officer).

The two programmes had started independently and hence the MOH staff did have some insight into the individual programmes and their observations that the combined programme was better are valuable.

“Definitely the programme took longer because the leadership component didn’t go through”. (Mpho, MOH Officer)

The funding for the combined programme was time limited and when the funding ended, the MSH team had to leave. However, as indicated in the previous discussion about the application of training, both hospital and MOH staff confirmed that they continued to use the leading and managing practices and some of the quality improvement methods they had learned. It is therefore not clear why when MSH left the programme; the locally trained LDP facilitators were not addressing this. It may relate to the organisational structure which had the LDP focus in one directorate of the MOH and the responsibility for accreditation in another or that people were moved, which was raised as a problem in the organisational issues. It also seems that the COHSASA team did not reinforce those aspects,

“... but then we just used the COHSASA standards. You see then there was nobody to talk to them about the QIL” (Mary, COHSASA Facilitator)

This does not confer with the positive responses relating to the application of training discussed above.

Theme 5: Benefits of the programme

The first research question:

‘Was there any benefit in the integration of the MSH Leadership Development Programme with the COHSASA Quality Improvement and Accreditation programme?’

One of the respondents referred to the COHSASA standards being the ‘what’ and the LDP as the ‘how’. The COHSASA programme does include assisting healthcare facility staff to use quality improvement methods to address shortfalls in the standard compliance. The leading and managing practices combined with practical methods, brought an added dimension. One respondent talked about the importance of training in soft skills. “as these do not come naturally to us all”. The leadership skills that were taught included soft skills, such as how to inspire and mobilise resources. The respondents talked about changes in behaviour and staff attitude, using words like, inspiring, initiative and innovation. A number of the respondents spoke about improved teamwork. Empowerment was an important factor and the hospital staff having a sense of ownership of the programme and also of their own challenges and feeling

able to deal with them. This concurs with the positive responses about the application of the standards and skills training to ensure sustainability. Also the intention of the MSH approach:

“The essence of the leading and managing part that people are able to be proactive and take on challenges without waiting for external assistance”. (Jon, MSH Manager)

The empowerment of staff as part of the theme of benefits, is in line with the findings of Marchal in Ghana,

‘The hospital management team, by triggering mechanisms of staff participation, empowerment and reciprocity it instigated a U turn in hospital performance’. (Marchal et al 2010, page 15).

Time was a factor for assessing the longer-term benefits and within the time that MSH and COHSASA were combined working together on the programme, the hospital did not achieve the required level of standard compliance for accreditation. The length of time given to hospitals in the accreditation programme was raised as an issue in a previous study on the COHSASA accreditation programme.

“Several intervention hospitals were still trying to achieve accredited status at the time of the second COHSASA survey, and in general the full impact of the program may take longer than the interval measured in this study”. (Salmon et al 2003; page iv)

Theme 6: Organisational Issues

Organisational issues emerged as a theme and within the theme there were issues at different levels in the organisation. The issue of hierarchy was raised as staff designated to coordinate programme activities were subordinate in rank to other staff whom they needed to influence. This perhaps results from how the staff were mandated to carry out specific roles and highlights the importance of the skills of influencing that were covered in the training.

Staff turnover was raised by respondents in all groups. Comments such as,

“...then they leave and it leaves a vacuum” (Kagiso, Hospital Senior Nurse).

and *“...then new people came in and this whole thing was lost”, (Mpho, MOH Officer)*

This implies there was no handover and also raises concerns about the depth of learning and the development of organisational memory, which seems to contradict the very positive responses given by hospital and MOH respondents about the way the training was applied and learning cascaded.

The MOH respondents referred to the fact that prior to the development of the combined programme, the LDP and accreditation programmes had been led by different directorates. This was an organisational reality, which continued throughout the programme. As the QIL programme developed and the MOH, COHSASA and MSH staff together were referred to as the QIL team, it appeared to be functioning well. However, with hindsight, I think that COHSASA and MSH could have better understood the organisational dynamics, and worked with the MOH to address this at the start of the programme to ensure clarity of the roles and responsibilities, and the necessary relationships to ensure success. When the MSH staff had to leave, this perhaps reduced the direct contact with those who had been trained as LDP facilitators who could have assisted with on-going support.

Contested leadership and followership

The findings indicate that the participants were mostly positive about the benefits of the programme and the impact of leadership on quality but within that theme and the theme of organisational issues there are a number of contradictory statements. From one at the hospital level indicating an active training programme to all levels of staff:

“I trained the hospital staff members ... on quality improvement activities and we used the skills from the QA/LDP training to cascade learning from the departmental management level to unit level, down to ward level ending with the individual staff”. (Kopano, Hospital Doctor).

Whereas the view of one the COHSASA team was that the leadership component was not carried through:

“You see that’s where we were working nicely together but then we just used the COHSASA standards. You see then there was nobody to talk to them about the QIL They stopped and then people lost interest”. (Mary, COHSASA Facilitator)

This response implies that combining of the programme was not as robust as intended. As stated earlier it is not clear whether this was partly because the leadership message was not reinforced by the COHSASA team. This together with the organisational

issues raised, speaks to the findings of Øvretveit, *“What a leader can achieve depends in part on the context created by higher-level leaders”*. (Øvretveit 2010; page 492). In his 2004 paper, Berwick states:

“A leadership development strategy is an inescapable part of any hopeful plan for improvement of care in developing nations”. (Berwick, 2004: page 1128).

In the development of the joint programme, while there was a clear national quality strategy, there was no reference made to any leadership strategy in the Ministry of Health, which goes back to the context created by higher-level leaders. (Øvretveit 2010; page 492).

In their study on leadership and improvement for the Health Foundation, the authors stated:

“Engagement and relationship skills are fundamentally important in leading improvement... more than task-related or conceptual skills”. (Flanagan et al, 2011: page 70)

This view is supported by one of the MOH respondents who identified the need for such skills:

“...and it’s to train people in these soft skills because they don’t come naturally to all of us”. (Dikeledi, MOH Officer)

Bahamon et al (2006) in their paper on the experience of MSH in developing the LDP stated:

‘Early in the change process, this person reaches an agreement with others on this challenge and becomes the change agent involving others in creating a vision of a better future that generates commitment’ (Bahamon et al 2006 page 659).

The programme focused on management and leadership development and there was no mention of the concept of followership. It could have been a factor that not all the staff bought into the process. Many could have been passive dependent followers, who need to be motivated and directed; or active, conformist followers, who support the leader and are motivated but do not act without instruction. Some indeed could have been alienated followers, who argue with the leader and are often sceptical. There were however, examples of exemplary followers:

“the areas where people were willing, changes were happening, where people would innovate and discuss and make the changes move on very well.”
(Thapelo, MOH Officer).

In the words of Grint: *“Followership is the anvil of leadership; the former can make or break the latter”*. (Grint et al 2011. Page 7).

Secondary statistical Evaluation Data

In the review of the secondary statistical evaluation data it was necessary to draw on the experience of COHSASA, having run the accreditation programme for twenty years. COHSASA has demonstrated that if all the necessary resources are available in a facility, together with good leadership, the programme should be able to progress to achieve accreditation within a two to three-year period. There is usually a limited increase in the scores during the initial period, as the staff need to put in place quality improvement plans, which could include the development of policies and information management which take time to demonstrate full implementation. Thereafter a gradual improvement of between five and ten in the overall scores could be expected at each evaluation period. The time taken depends on a variety of factors, the first being the level of compliance with the standards at the Baseline Survey, thereafter the availability of the resources to comply with the standards. It should be noted that the standards are considered a ‘blueprint for good practice’ and do not include requirements for any resources that are not considered essential in a health care facility. The issue of the availability of resources bears out the findings of Ramjee on accreditation in public and private sector hospitals in the COHSASA programme,

“The wide range of public sector scores points to a variety of challenges across regions and levels of hospitals – not least of which are resource challenges”.
(Ramjee et al, 2016, Slide 14 of presentation to ISQua Conference)

The overall score for the hospital and the management and leadership scores increased from 47 to 63 and from 40 to 62 respectively. It is difficult to draw any inference about the impact of the implementation of the LDP from the standard compliance data as scores do not indicate a better improvement than could be expected during a quality improvement programme using the COHSASA approach alone, but there are many other factors that are not part of this research study.

Possible limitations of the method, effectiveness and limitations in the design strategies

I was successful in interviewing representatives from all the organisations involved in the programme and a cross section of professionals and disciplines in the Ministry of Health and the implementing hospital. I believe the participant observer / researcher role assisted with this. However, this role did require me to be very aware of any personal preference or bias that I have and which could have influenced my approach to the interviews, or been applied to the findings.

It was useful to have both qualitative and quantitative data from the interviews and the standards compliance scores. The lack of data from the managing and leading questionnaires was disappointing. However, the study was primarily ethnographic and I think did succeed in eliciting the perceptions of the participants about how they experienced the combined programme.

The planned programme was time limited by the funding mechanism and it took longer to set up than anticipated. The direct involvement of MSH therefore ceased before the participating hospital was ready to undergo an external survey with a view to achieving accreditation. Nonetheless the process of implementing the programme was established and well known to the participants.

With the study being set in the context of work based learning, reflective practice was an important component. There is learning both on a personal and organisational level. Before I started the research, I had not appreciated the benefits and challenges of being an insider researcher. The challenges were the greatest learning, in that I had to reflect on every aspect of setting up the research, from drafting the research questions, the literature review and designing the interview questionnaires. At each point, I had to reflect on my motivations to ensure that I did not allow any of my preferences to influence my choices to ensure complete objectivity. At an organisational level, it was important to separate the research from the day-to-day operations. At the time of carrying out the interviews this was particularly challenging as I found some of the responses so interesting and wanted to share them with colleagues. The need for discipline was paramount to ensure confidentiality and objectivity. The main benefit was that I understood the context of the programme and the work that had gone into developing it. The personal relationships were both a challenge and a benefit as I had to guard against familiarity but overall I think they were a benefit in being able to access the respondents and also being seen as a trusted, professional colleague.

Chapter 7: Conclusions

The aim of the research was to assess whether there was benefit to the client in integrating the MSH Leadership Development Programme and the COHSASA Quality Improvement and Accreditation programme.

There were four objectives set at the beginning of the research:

To assess whether the inputs of both parties at the beginning of the programme led to the integration of the delivery of their inputs.

To assess whether the integrated programme delivered better adoption by the recipient organisations.

To assess if there was a collaborative action plan for implementation support from both COHSASA and MSH.

To assess whether the use of the Leadership and Management practices assessment tools led to a better compliance with the management and leadership standards in the service elements and the facility as a whole. (The service elements are the groupings of the standards for each department in the hospital, for example the Surgical Service Element would include all wards in the surgical department).

The aim specifically referred to the benefit to the client. This was addressed in the first research question. The objectives were realistic and measurable. The second objective was addressed in the first research question. The fourth objective was addressed in the second research question.

The responses by the MSH and COHSASA respondents to the questions during the semi-structured interviews demonstrate that the first objective was met. The respondents articulated how the process of integration occurred and it is clear that the programme linked the inputs of both parties, perhaps best summarised by “COHSASA provided the ‘what’ and MSH the ‘how’”.

I do not think my research addressed the second objective effectively as there was no direct comparison with the implementation of the two individual programmes in other facilities in the country. Any comparison was anecdotal.

The third objective was set to assess whether the implementation and support was ‘joined-up’. From most respondents’ answers, this would appear to be the case, although the fact that funding for the combined programme ended, created a sense that MSH had pulled out.

It was not possible to respond to objective four as the completed Leadership and Management practices assessment tools were not available and the data had not been collated and analysed fully by MSH due to time pressures. No inference could be drawn from the secondary statistical data to show that there was better compliance with the management and leadership standards.

The first research question was:

‘Was there any benefit in the integration of the MSH Leadership Development Programme with the COHSASA Quality Improvement and Accreditation programme?’

The study has shown that there were definite benefits from integrating the programmes. Respondents gave specific examples of these benefits including the combining of a standards-based approach with a skills-based approach. The MOH and hospital respondents were able to articulate how they had applied the leading and managing practices to the problem solving needed to address the non-compliance of the COHSASA standards. There were also comments to indicate that they perceived the process to be going faster when the leadership component was active. The MOH and hospital recipients all commented that they had continued to use the managing and leading practices in their daily work and personal lives, it is therefore unclear why the leadership component was not carried through as the training was geared to enable the recipients to become self-sufficient.

The second research question:

‘As a result of the integration of the two programmes, has there been any greater improvement in compliance with the COHSASA healthcare facility standards than would be expected when the COHSASA programme is delivered independently?’

It is not possible to answer this research question positively as the standard compliance data did not show any particular improvement over and above what would be expected in the accreditation programme with hospitals at a similar level of infrastructure and resource.

Recommendations

The combination of the standards based and skills based programmes clearly resonated with many of the respondents. COHSASA should review with the MOH how the skills that were taught, and are still being used by staff, can be better integrated into the accreditation programme in order to improve the overall standards compliance, and how quickly this can be achieved.

The functioning of organisational structures, and the relative roles and responsibilities of departments in client organisation, should be discussed and understood explicitly by technical assistance partners at the beginning of any programme.

Learning from this pilot programme could inform how COHSASA and MSH may explore the opportunity for future collaboration.

Reflections upon the research process

The study method was suitable for the subject, and as a retrospective study, I think it is valuable. It would have been more beneficial to have posed the research questions at the time that the programme was started and to have been able to have all the available data, including the leadership and management questionnaires. Nonetheless the benefit of the retrospective study has been that the sustainability of some of the methods and practices has been demonstrated.

Being a senior member of one of the organisations that was part of the research had benefits and drawbacks, the main drawback being seen as 'too close' to the programme and not objective. I think that I was able to deal with this effectively and maintain an objective standpoint. The key benefit was an understanding of the context in which the programme was developed and being able to contact a good cross section of participants as interviewees. Also my passion for improving the quality of services for patients in all settings ensured my commitment to finish the research.

Contribution to practice

This research has contributed knowledge and practice learning to the fields of quality improvement, leadership and management in healthcare. There is a lack of evidence of the direct relationship between leadership and quality improvement and I believe this research contributes to this area of knowledge. As discussed earlier, developments in quality and leadership should be linked to the local strategies to ensure the context is set for participants. The importance of the role of followers cannot be ignored nor can the need for the development of soft skills to build relationships and engagement.

Carrying out the research has been extremely useful for me as the, now, Chief Executive of COHSASA, in looking at how we need to develop our programmes to meet the needs of our clients more effectively. It has also confirmed my belief that collaboration with other organisations and subject experts can be the most effective way to deliver the best value programmes to clients. The most important factor of improvement in the health sector is sustainability to ensure that patients get better care and I believe this programme posed some useful questions on how to make improvement sustainable. The role of leadership and followership in implementing improvements are applicable to many areas and this research offers transferable practice and learning that may be useful to others implementing development programmes in low and middle-income countries.

Further research

The LDP uses methods to improve leading and managing practices, many of which contribute to the quality improvement activity. If the programmes could be integrated more effectively, further research could explore first whether this could lead to accreditation being achieved more quickly. A second research question would be 'Will the concurrent programmes lead to sustainable improvement?' I would be interested in exploring these post-MProf.

Dissemination

The findings of this research will be disseminated to all the participating organisations and I plan to publish the results in a referred journal with my academic advisors and promote the research at conference presentations such as the international conference of the International Society for Health Care (ISQua).

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Appendices

Appendix 1

EXAMPLE OF COHSASA ACCREDITATION STANDARDS



SERVICE ELEMENT 1: MANAGEMENT AND LEADERSHIP

OVERVIEW OF MANAGEMENT AND LEADERSHIP

Providing excellent patient care requires effective management and leadership, which occur at various levels in a healthcare organisation. At the governance level there is an entity (for example, a ministry of health), an owner(s), or group of identified individuals (for example, a board or governing body) responsible for directing the operation of the organisation and accountable for providing quality healthcare services to its community or to the population that seeks care.

Within the organisation there are individuals assigned the responsibility of ensuring that the policies of governance are implemented, and that there are systems of administration and organisation to provide excellent patient care.

At departmental and service level, heads of departments and services ensure effective management and leadership.

Leadership comes from many sources in a healthcare organisation, including governing leaders, clinical and managerial leaders and others who hold positions of leadership, responsibility and trust. Each organisation must identify these individuals and involve them in ensuring that the organisation is an effective, efficient resource for the community and its patients.

In particular, these leaders must identify the organisation's mission and make sure that the resources needed to fulfil this mission are available. For many organisations, this does not mean adding new resources but using current resources more efficiently - even when they are scarce. Leaders must work well together to co-ordinate and integrate all the organisation's activities, including those designed to improve patient care and clinical services.

Effective governance, management and leadership begin with understanding the various responsibilities and authority of individuals in the organisation, and how these individuals work together.

Those who provide governance, management, and/or leadership have both authority and responsibility. Collectively and individually they are responsible for complying with laws and regulations and for meeting the organisation's responsibility to the patient population served.

Over time, effective management and leadership helps overcome perceived barriers and communication problems between departments and services in the organisation, and the organisation becomes more efficient and effective. Services become increasingly integrated. In particular, the integration of all quality management and improvement activities throughout the organisation results in improved patient outcomes.

Standards

1.1 Governance of the organisation

1.1.1 Governance responsibilities and accountabilities are described in legislation, policies and procedures or similar documents that show how these duties are to be carried out.

Intent of 1.1.1

There is a governing body that is responsible for directing the operation of the organisation and it is accountable for providing quality healthcare services to its community or to the population that seeks care. The responsibilities and accountabilities of this entity are described in a document that shows how these duties are to be carried out. The governing body's responsibilities and accountabilities are known to those responsible for management within the organisation.

It is important that the organisation has clear leadership, operates efficiently, and provides quality healthcare services. The lines of communication to achieve this are presented in an organisational chart or other document. The identification of individuals in a single organisational chart does not, by itself, ensure good communication and co-operation between those who govern and those who manage the organisation. This is particularly true when the governance structure is separate from the organisation, such as a distant owner or national or regional health authority. The process for communication and co-operation with the governance structure must therefore be made known to the organisation's managers and be used by them.

The responsibilities of governing bodies lie primarily in approving plans and documents submitted by the managers of the organisation. Those elements of management requiring approval by the governance structure are documented. The hospital board's relationship with the governance structure and the hospital management are described in written documents.

1.1.1 Criteria

1.1.1.1 The organisation's governance structure is described in written documents and is known to the staff of the organisation.

1.1.1.2 There is an organisational chart or document that describes the lines of authority and accountability between the governance structure and the organisation as well as within the organisation.

1.1.1.3 Those responsible for governance approve and make public the organisation's mission statement.

1.1.1.4 Those responsible for governance approve the managerial policies and plans to operate the organisation.

1.1.1.5 Those responsible for governance approve the budget and allocate resources required to meet the organisation's mission.

1.1.1.6 Those responsible for governance appoint the organisation's senior manager(s) or director(s).

1.1.1.7 Those responsible for governance collaborate with the organisation's managers.

1.1.1.8 Those responsible for governance receive and act upon reports of the quality programme, at least quarterly.

1.1.1.9 Those responsible for governance receive and act upon reports on risk management, at least quarterly.

Those responsible for governance evaluate the performance of the organisation's senior manager at least annually.

1.2 Management of the organisation

1.2.1 A senior manager is responsible for operating the organisation within applicable laws and regulations.

Intent of 1.2.1

The senior manager is appointed by the governing body to be responsible for the overall, day-to-day operation of the organisation. These responsibilities are documented and known to the personnel of the organisation. The individual appointed to carry out these functions has the education and experience to do so.

The senior manager is responsible for the implementation of all policies, which have been approved by the governing body.

1.2.1 Criteria

1.2.1.1 The senior manager manages the day-to-day operation of the organisation, including those responsibilities described in the position description;

1.2.1.2 The senior manager has the education and experience to match the requirements in the position description.

1.2.1.3 The senior manager carries out approved policies for management functions;

1.2.1.4 The senior manager assures compliance with applicable laws and regulations;

1.2.1.5 The senior manager responds to any reports from inspecting and regulatory agencies;

1.2.2 A senior manager implements processes to manage and control the organisation.

1.2.2 Criteria

1.2.2.1 The senior manager facilitates communication and co-operation between the organisation's governance structure, management and the community.

1.2.2.2 The senior manager implements processes to manage and control human, financial and other resources;

1.2.2.3 The senior manager ensures that the required physical facilities, installations and equipment are available and are used optimally to provide the specified services.

1.2.2.4 The senior manager ensures the implementation of risk management processes and activities.

1.2.2.5 The senior manager implements processes to monitor patient and staff expectations and satisfaction.

1.2.2.6 The senior manager implements processes for quality management and improvement.

1.2.2.7 The senior manager implements processes to monitor the quality of clinical and other services.

1.3 Management of departments and services

1.3.1 Identified departmental or service managers control clinical and managerial activities in each department or service.

Intent of 1.3.1

The clinical care, patient outcomes and overall management of a healthcare organisation are only as good as the clinical and managerial activities of each individual department or service.

Good departmental or service performance requires clear leadership from a qualified individual. The qualifications of departmental managers should be appropriate to the department i.e. suitable paediatric, ICU, operating theatre or information technology qualifications, as applicable. In large departments or services, clinical and administrative leadership may be separate. In such a case, the responsibilities of each role are defined in writing.

Documents prepared by each department define its goals, identify current and planned services, and establish the knowledge, skills and availability of the personnel required to assess and meet patient care needs. The leaders of each department or service make their human resources and other resource requirements known to the organisation's senior managers. This helps ensure that adequate staff, space, equipment and other resources are available to meet patient needs at all times. The organisation's management provides departmental and service managers with data and information needed to manage and improve care and service. Patient care is not provided when special resources are not available.

Clinical services provided are co-ordinated and integrated within each department or service. For example, there is integration of medical and nursing services. Also, each department or service works to co-ordinate and integrate its services with other departments and services. The management of the organisation's organisational chart guides departmental/service staff in adhering to correct lines of communication. Each department or service documents the lines of communication within that department or service. Unnecessary duplication of services is avoided or eliminated to conserve resources.

1.3.1 Criteria

1.3.1.1 The organisation ensures that a qualified individual manages each department or service in the organisation.

1.3.1.2 The responsibilities of each departmental manager are defined in writing.

1.3.1.3 The departmental or service manager implements processes to manage and control human, financial and other resources.

1.3.1.4 The departmental or service manager ensures that there are sufficient personnel to provide the services.

APPENDIX 2

ASSESSMENT TOOL ON LEADING AND MANAGING PRACTICES (ORGANIZATION VERSION)

Developed by the PLAN health Program
Management Sciences for Health

FACILITATORS GUIDE

What this tool is designed to help you achieve

- Establish a baseline data on general perception of staff on the application of leading and managing practices within the organization
- Identify areas in the Leading and Managing Practices that needs to be focused on during the Leadership Development Program
- Identify key leading and managing strengths and development needs that need to be considered /addressed within the organization
- Monitor leading and managing practices changes overtime
- Evaluate the impact of the application of the eight leading and managing practices in the Organization overtime

Directions to facilitators:

This questionnaire is intended to be applied confidentially (filled-in by individual staff and not as a result a consensus decision of a group of staff).

It is important to include staff from all levels (senior management, midlevel and lower level) and departments or units.

Please assure participants that this survey is:

NOT commissioned by their organization for the purpose of performance management (promotion, demotion or other punitive measures)

NOT a benchmarking tool to compare your organization with other organizations

ASSESSMENT TOOL ON LEADING AND MANAGING PRACTICES
(ORGANIZATION VERSION)

Developed by the PLAN health Program
Management Sciences for Health

Name of Organization: _____

Date of Assessment: _____(dd/mm/yy)

NOT commissioned by MSH as a tool to assess the suitability or otherwise of your organization for grants or other future relationship

Dear Respondent,

In order to assess the current state of the application of leading and managing practices by individuals within your organization, we seek your participation by honestly filling out the questionnaire below.

Thank you for your participation.

Please read each item overleaf and indicate your selection by a circle around the appropriate number in the 'select your response' column using the rating scale of 1 to 5 below.

Rating scale

Strongly disagree

Disagree

Don't know

Agree

Strongly agree

ORGANIZATION LEVEL ASSESSMENT

LEADING PRACTICES

1. Scanning	(Select your response)
In our organization, Managers leave the office to learn about the needs of our clients and demonstrate awareness of our clients' needs	1 2 3 4 5
In our organization, we identify and respond to trends in the internal and external environment	1 2 3 4 5
In our organization, managers make visits to learn about working conditions of staff and look at staffs abilities, motivations, and challenges	1 2 3 4 5
In our organization, managers are aware of how their behavior affects others- clients and staff alike	1 2 3 4 5
2. Focusing	(Select your response)
In our organization, our work is directed by a well-defined mission and strategy, and priorities are clear	1 2 3 4 5
In our organization, we have a shared, vivid and challenging picture of the future	1 2 3 4 5
In our organization, staff's contributions are directed towards the achievement of strategic goals and priorities	1 2 3 4 5
In our organization, we work as a team to identify critical challenges and set priorities to satisfy our clients' needs	1 2 3 4 5
3. Aligning/ Mobilizing	(Select your response)

In our organization, Internal and external stakeholders understand and support the organization's goal and have resources mobilized to reach these goals	1 2 3 4 5
In our organization, staff are recognized and rewarded for achieving objectives contributing to our goals	1 2 3 4 5
In our organization we look for ways to ensure that systems, structures, and tasks are in line with our goals and strategies	1 2 3 4 5
In our organization, managers know how to bring their individual personal goals and those of others in line with organizational strategies	1 2 3 4 5
4. Inspiring	(Select your response)
In our organization, the work climate infuses confidence in our ability to do challenging work	1 2 3 4 5
In our organization, the working environment makes me comfortable to share new ideas one of continuous learning,	1 2 3 4 5
In our organization, our leaders model commitment and enthusiasm in pursuit of our mission	1 2 3 4 5
In our organization, the work climate is such that staff show commitment even when setbacks occur.	1 2 3 4 5

MANAGING PRACTICES

1. Planning	(Select your response)
In our organization, we develop multi-year and annual plans to guide activities	1 2 3 4 5
In our organization, we anticipate risks and put plans in place to mitigate them	1 2 3 4 5
In our organization, we develop operational plan derived from organizations strategic plan to guide achievement of short term objectives	1 2 3 4 5
In our organization, we allocate adequate resources (money, people and materials) during the planning stage	1 2 3 4 5
2. Organizing	(Select your response)
In our organization, Human Resources, Finance, logistics, quality assurance, operations, information, and marketing effectively support planned activities	1 2 3 4 5
In our organization, staff capacities are aligned with planned activities e.g. no emergency duties or unscheduled activities	1 2 3 4 5

In our organization, staff are organized and aware of job responsibilities and expectations	1	2	3	4	5
Our organization has functional structures, systems and processes in place for efficient operations	1	2	3	4	5
3. Implementing	(Select your response)				
Our organization systems are integrated to co-ordinate work flow effectively	1	2	3	4	5
We routinely use data collected for decision making	1	2	3	4	5
In our organization, we coordinate programs with other departments and programs	1	2	3	4	5
In our organization, we adjust plans and allocate resources as circumstances change	1	2	3	4	5
4. Monitoring and Evaluating	(Select your response)				
In our organization, we monitor and reflect on progress against plans and make adjustment as required	1	2	3	4	5
We seek to improve work processes, procedures and as a team based on data collected	1	2	3	4	5
We routinely collect data on performance and progress report and use this data for decision making and improvement plans	1	2	3	4	5
The organization continuously updates information about the status of achievements and results and applies on-going learning and knowledge	1	2	3	4	5

Thank you for completing this survey!

Appendix 3



Version Number 2

Participant Identification Number:

CONSENT FORM

Title of Project: Leadership Development to Support Quality Improvement

Name of Researcher: Jacqueline Stewart

Please initial box

I confirm that I have read and understand the information sheet datedfor the above study and have had the opportunity to ask questions.

1

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

2

I agree that this form that bears my name and signature may be seen by a designated auditor.

3

I understand that my interview may be taped and subsequently transcribed.

4

I agree to take part in the above study.

5

Name of participant Date Signature

Name of person taking consent Date Signature
(if different from researcher)

Researcher Date Signature

1 copy for participant; 1 copy for researcher;

Contact details:

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Appendix 4



MIDDLESEX UNIVERSITY

SCHOOL OF HEALTH AND EDUCATION

Participant Information Sheet

Study title

Leadership Development to Support Quality Improvement - A review of the development of the Quality Improvement and Leadership Programme (QIL)

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please feel free to ask me if there is anything that is not clear or if you would like more information.

Thank you for reading this.

The purpose of the study

The study is designed to assess the first iteration of bringing together the Leadership Development Programme developed by Management Sciences for Health (MSH) and the Quality Improvement and Accreditation Programme developed by The Council for Health Service Accreditation of Southern Africa NPC (COHSASA) – the Quality Improvement and Leadership Programme (QIL). It is a small study to hear the experiences of a sample of those who were involved in the development of the joint programme in the two organisations and some participants from the Ministry of Health and one of the participating hospitals. The study is not to assess the compliance of the hospital with the standards. This is a retrospective study and the data collection will be done through semi-structured interviews. The study will take four months to complete with the proposed time line being from October 2015 to February 2016.

Why have I been chosen?

This is a small study to understand the views of a cross section of people who were involved from the different organisations. Ten people are being invited to be interviewed from the Ministry of Health, including one each from a participating hospital, Management Sciences for Health (MSH) and the Council for Health Service Accreditation of Southern Africa (COHSASA).

Do I have to take part?

Taking part in this research is voluntary. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. The data collected from you will be anonymised and the hospital you are from will not be named.

What do I have to do?

You will be invited to take part in an interview either face to face or by telephone, which should take no more than 45 – 60 minutes. I aim to collect information to answer the research question through the use of a semi-structured interview to find out how people experienced the programme.

What are the possible benefits of taking part?

There are no benefits to taking part in this study other than the possible further development of the training programme.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it. All the data and information collected, analysed and reported will comply with the data protection legislation in Botswana and South Africa.

What will happen to the results of the research study?

The results of the research will be anonymous and no participant names will be shown. The findings from the study will be included in a research degree project report and held on the University e-repository. A summary of the findings will be available on request from the researcher.

Who has reviewed the study?

The Research Ethics Committee of the Health Research Unit at the Botswana Ministry of Health and the Middlesex University Health and Social Care Ethics Sub-committee.

Contact for further information

Researcher:

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Research Supervisor:

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+44 (0) 20 8411 5000

You may keep this information sheet and the signed consent form.

Thank you for taking part!

Appendix 5

Interview Questionnaire: Ministry of Health and Hospital Staff

Date:

ID:

Baseline data at the start of an interview		
Higher Educational and practice background:		
Demographic information: Gender: M F	Age: 20 – 30; 31 – 40; 41 – 50; 51 – 60;	Nationality: Country of residence:
1. Describe your role in the organisation:		
2. What experience did you have of the Management Sciences for Health (MSH) Leadership Development Programme?		
3. What experience did you have of the Council for Health Service Accreditation of Southern Africa's (COHSASA) Quality Improvement and Accreditation Programme?		
4. How were you introduced to the Quality Improvement and Leadership (QIL) Programme?		
5. In which year were you first introduced to the programme?		

<p>6. Please describe training you were given at the start of the programme.</p>
<p>7. Where did the training take place?</p>
<p>8. Who were the trainers?</p>
<p>9. Can you describe how you were able to apply the training to the quality improvement activities?</p>
<p>10. Can you describe how you were able to share the training with others involved in the quality improvement activities?</p>
<p>11. Did you complete a leadership development questionnaire at the start of the programme and six months later?</p>
<p>12. If yes, are you aware of any changes that happened in the rating?</p>
<p>13. How do you think the leadership input affected the quality improvement activity?</p>

14. What are the most important aspects of the QIL programme for you?
15. Can you give details of any specific parts of the programme that were helpful to you?
16. Can you give details of any specific parts of the programme that were less useful to you?
17. Can you describe the benefits of the QIL programme to your hospital?
18. Can you describe the deficits of the programme?
19. Are there any other comments or observations you would like to make?

Appendix 6

Interview Questionnaire: MSH and COHSASA staff

Date:

ID:

Baseline data at the start of an interview:		
Higher Educational and practice background		
Demographic information: Gender: M F	Age: 20 – 30; 31 – 40; 41 – 50; 51 – 60;	Nationality: Country of residence:
1. Describe your role in the organisation:		
2. How were you involved in the development of the Quality Improvement and Leadership (QIL) programme between COHSASA and MSH?		
3. Can you describe how the COHSASA Quality improvement and accreditation programme and the MSH Leadership Development programme were brought together?		
4. How were you involved in the training of staff at the Ministry of Health and facilities?		

<p>5. Can you describe how the COHSASA and the MSH training methods and content were combined?</p>
<p>6. How did you manage the data collected from Management and Leadership assessment tools?</p>
<p>7. How did you manage the data collected from standards assessments captured into the COHSASA Quality Information System (CoQIS)?</p>
<p>8. Can you describe the benefits of the QIL programme?</p>
<p>9. How would you assess if the QIL programme has been more or less beneficial than your original programme?</p>
<p>10. Are there any other comments that you would like to add?</p>

Appendix 7

Example of the process of highlighting and coding to identify categories in transcript of semi structured interviews.

Codes

T training
C content
PS Problem Solving
L leadership
Q quality
A applying training
PO Leadership part stopped – pulled out
TW team work
I impact of leadership on quality
CL cascade learning
P people moved
INT integration
Pr process
E empowerment
R resistance
M methods
C collaborative approach
B benefits of the programme
O ownership
D use of data
S organisational issues
BC change
Cull culture

Respondent: 004

What is your Higher educational and practice back ground?

OK yes I have a degree in nursing a Bachelors

Female

Age band

41 – 50

Nationality

Botswana

When did you start that process?

When MSH and COHSASA came for the first time I was in the first group to be trained and I think that was around 2009. It was x who came and y.

What experience did you have of the COHSASA quality programme - did you have any experience before that time?

In fact when they came here, they did training and introduced us to the COHSASA
T programme and I was among the first group that was trained to be able to do like

quick auditing, they trained us in the accreditation process, but not like a certification course, it was just a three days' workshop because after the assessment we were supposed to go on the ground and check on things. So I was trained for a three day workshop. And we also did onsite training which meant I was able to do quick auditing. And then when they would come, the team we were supposed to go and be part of the assessment.

So you were really in right at the very beginning of it?

Yes

So who formed that team that went and reviewed the facilities?

It was people from MSH, COHASA, and the ministry

Do you remember where that training took place?

It took place here in the ministry and then for the assessment we were doing it at x

And who did that training?

It was x and y

So once you've been through the training can you describe how you are able to apply the training to quality improvement activities?

You mean the training that x and y did?

Yes. Was the master trainer at the same time, or was there different training for that?

A D (What) Yes it was very helpful because after COHSASA came on the ground and did the assessment we were trained on the ground with the information from COHSASA and then we were able to interrogate the data with the facilities and help them to understand the results and then we were able to help them with the next step and then from there now we were using the MSH programme to help them to deal with their problems as identified in the assessment. **INT A (How)**

D Yes after that we were able to help them interrogate the data and after that we were able to apply the practice.

A Also after applying whatever we have done to close the gap then we could assess against COHSASA assessment and say how far have we gone. And then we could even assess ourselves even before COHSASA would come.

So you were able to test the progress?

Yes.

Can you describe how you were able to share the training with others involved in the quality improvement activities?

CL What we did was - We had a plan to cascade like going to the facilities to help them to understand. Because at least we had been trained.

TW And then in each and every areas there were team leaders - what were they called? I am getting older so I have forgotten some of these things! The team leaders – we were able to tell them what is entailed in the assessment. Because if you want them to learn to assess themselves but they kind of want to sometimes

CL hide things – so we tried to help them to understand so that they were able to do their self- assessments correctly.

So when you were doing this training with the assessments were you using what you had learned in the LDP as well?

TW After the training we formed teams in all the facilities and

CL we showed them the whole process of identifying a problem, and trained them to solve the problem using the LDP format – we were cascading the whole thing to the lower levels so they were able to make progress.

CL We had everything, we had training manuals – so everything we had been taught were able to give to them. To share the information.

I am not sure how many people we trained overall but a team would comprise 5 to 8 members. We had a team from x, another team from y, another team from z, we had another team from a, we had a team from b and a team from c and d, another team from e, we also had a team from f clinic and g. These were the teams that we trained. We were busy. **CL TW**

Did you complete the leadership development questionnaire at the start of the programme and six months later?

L You mean when we were trained. Yes I did it once - at the start and then I did it after the training and gave it to x. Then we applied it to all of them before the training.

If yes, are you aware of any changes that happened in the rating?

When we did it the second time we could see there was changes. You remember when we first started there was COHSASA and it was called the COHSASA project

BC O but after, when we had trained they came back and the language had changed. They were calling it accreditation and quality improvement in our health facility so we could see that change.

Although it still had pockets where they would forget and still call it the COHSASA project.

BC In me I could see very much change in self – after the programme I could see that whatever you do, you do can change it.

How do you think the leadership input affected the quality improvement activity?

L I really feel that it was very, very important. It taught people that no matter whatever level you are at, you are a leader. Whatever you are at, whether you are a cook or a cleaner, you are supposed to take charge where you are.

O You do not have to go to a higher level, where you are you must see the problems as their problems.

BC You can take charge of changing the situation.

TW So we inculcated the team spirit with the hospital – the facility people – so that as they moved they could all see themselves as contributing to the issue. So people should work as a team.

What are the most important aspects of the QIL programme for you?

Ok, I think the most important thing that was anticipated when QIL was done was bringing the two together was to help the accreditation and leadership to be to more closer. **INT**

So to use the tools to help the service element scores. So if a service element had non compliant something so we were using the knowledge and skills of the LDP –to bring those to partially compliant or compliant. **INT**

PS Because the LDP had a problem solving component so it was anticipated that we would use the challenge model to focus on the non compliants and partially compliants in each service element.

Can you give details of any specific parts of the programme that were helpful to you?

B I have learned a lot as an individual. Even now I am still using the learning from the project, especially when I am faced with a situation, you do not look for another person to be a contributor, it helps you to really focus and to come up with some ways that you can really use to solve the problem at hand rather than saying, I cannot do it somebody else must come and solve my problem. **PS**

So that has helped me in that area.

Can you give details of any specific parts of the programme that were less useful to you?

Not really. I would not say there were any areas that were not useful to me.

Can you describe the benefits of the QIL programme to the facilities?

You mean like the whole programme?

Yes, in your role, can you see how the QIL programme has benefitted them now?

Yes if you look at the facilities that are under the accreditation programme. Yes let me give you an example. At the end of last year there was disaster in the area that x hospital is responsible for and that when we saw that had it not been for this programme it would have been worse. Only two people died, the others when they **B** reached x hospital they were well managed because people knew what they were supposed to do and things were in place at the right time not like whether there are patients or not, that all the time things are where they are supposed to be so that you **B** are ready. Even people at x hospital said it was the accreditation process that prepared them. Even if you go to y hospital if you go to z hospital, the facilities that are under the process, the people are different you see different behaviour, the **BC** people they are like - the people are working together to do the right things. **TW**

Can you describe the deficits of the programme?

I think one of the challenge was when they brought the two programmes together as QIL, we had hoped for the good but as it moved on the leadership part of it kind of died away. **PO**

If people get transferred they are in and out of this facility then new people came in and this whole thing was lost. **P**

Like in all these facilities we thought that people would be speaking the same language when it comes to quality but you would see something needs doing and when you come back you see it is still not done. Because now I thought when QIL came into play the leadership part of the programme became a bit dormant. **PO**

That is interesting as my understanding was that you and others were trained as master trainers to keep that going to keep people refreshed. Did that not happen?

P Because people were shifted around and new people came into the programme who were not trained. And it became difficult because they did not know anything about the leadership programme. So I think it was more an implementation problem by the Ministry not the QIL programme itself.

P I think it was a leadership change who did not know what it was all about. It was difficult because they moved people around.

S Also the people trained in LDP were in a different directorate that had a contribution to the whole process.

Are there any other comments or observations you would like to make?

Basically I will say that the whole thing started well with a vibe. But I am not sure as it took us long and to get a facility to be accredited and now that vibe is dying away, even at facility level. **PO**

So maybe we need to find a way of resuscitating it back. Hopefully something will come. I know they are preparing for the external assessments. I know the majority of people here are not thinking that we might get something.

And are people, like you are, still using the management and leadership practices?

Well it's to a smaller degree. Some people have forgotten. When I am out there now as a xxx some people say they think the LDP could help to drive accreditation. **B**

P But here we have different leadership who were not here when it was done and they don't know it. When we can introduce it to new management members probably we can go somewhere. Maybe we need to share with the new management and encourage them to use it. **S**

M I loved the programme so much and it gave us lots of tools to use.

Appendix 8



School of Health & Education
The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 020 8411 5000

26th October 2015

HEESC APPLICATION NUMBER: MPr01Jacqueline Stewart and Dr Gordon Weller

Dear Jacqueline and Dr Weller

Re your application titled: "Leadership Development to Support Quality Improvement".

Thank you for submitting your revised application. I can confirm that your application has been given approval from the date of this letter. Please ensure that you contact the ethics committee via Leeann Bradley l.f.bradley@mdx.ac.uk if there are any changes to the study to consider possible implications for ethics approval. The committee would be pleased to receive a copy of the summary of your research study when completed.

Please quote the application number in any correspondence.

Good luck with your research.

Yours sincerely

Kay Caldwell

Professor Kay Caldwell
Health and Social Care Ethics Committee

Appendix 9

TELEPHONE: 363 2766
FAX: 391 0647
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE RD



Republic of Botswana

MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE

REFERENCE NO: HPDME 13/18/1 IX (412)

19 June 2015

Health Research and Development Division

Notification of IRB Review: New application

Jacqueline Stewart
P.O.Box 676 Howard Place
Cape Town
7450 South Africa

Protocol Title: **LEADERSHIP DEVELOPMENT TO
SUPPORT QUALITY IMPROVEMENT**

Name of Sponsor:	N/A
HRU Approval Date:	18 June 2015
HRU Expiration Date:	17 June 2016
HRU Review Type:	HRU reviewed
HRU Review Determination:	Approved
Risk Determination:	Minimal risk

Dear Ms Stewart

Thank you for submitting new application for the above referenced protocol. The permission is granted to conduct the study.

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should also be submitted to all other relevant authorities.

Continuing Review

In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomoiso Motlhanka, e-mail address: kgmmotlhanka@gov.bw. As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form.

Amendments

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomoiso Motlhanka, e-mail address: kgmmotlhanka@gov.bw. In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

Reporting

Other events which must be reported promptly in writing to the HRDC include:

- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr. P. Khulumani at pkhulumani@gov.bw, Tel: +267-3914467 or Lemphi Moremi at lemoremi@gov.bw or Tel: +267-3632754. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely



P. Khulumani
For Permanent Secretary



MINISTRY OF HEALTH

Vision: Model of Excellence in Quality Health Services

Values: *Justice, Equity, Timeliness, Customer Focus, Teamwork, Accountability*

